Supreme Court, U.S.
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NO. _____

IN THE
SUPREME COURT OF THE UNITED STATES

PATRICIA W. BUCE,
Petitioner

v.

ALLIANZ LIFE INSURANCE COMPANY, f.k.a. NORTH AMERICAN LIFE AND CASUALTY COMPANY,
Respondent

Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

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PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Petitioner made a claim for ERISA accidental death benefits following her husband's death. The last paragraph on the last page of the plan's SPD, under the sub-heading "Plan Documents", contained a statement that "[t]he Plan is to be interpreted in accordance with the laws of the State of Georgia." Reversing the District Court's decision in favor of the widow's claim for benefits, a two-Judge majority of the Eleventh Circuit panel below held that when an ERISA fiduciary inserts a purported "choice of state law" provision in an SPD, it has effectively "contracted out" of the Federal Common Law that governs ERISA.

I. Whether the Eleventh Circuit's decision directly contradicts this Court's decisions in Contract Pipe & Prods. v. Constr. Laborers Trust, 508 U.S. 602 (1993) and Connolly v. Pension Benefit Guaranty Corp., 475 U.S. 211 (1986), that parties cannot "contract out" of federal ERISA law?

II. Whether the Eleventh Circuit's decision directly contradicts decisions of this Court and other Courts of Appeals that the federal law of ERISA may not be "supplanted" by state common law doctrines?

III. Whether the Eleventh Circuit's decision directly contravenes ERISA's stated policy considerations of uniformity and protection of ERISA plan participants and beneficiaries?

PARTIES

Counsel of Record for Petitioners certifies that the following listed parties, including parent and subsidiary corporations have an interest in the outcome of this case.

Allianz Life Insurance Company of North America, f/k/a North American Life and Casualty Company

Patricia W. Buce

LifeUSA Holding Company, Inc.

LifeUSA Insurance Company

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PETITION FOR WRIT OF CERTIORARI

This case presents an important issue of federal law with the potential to affect every ERISA plan, and the rights of every ERISA plan participant and plan beneficiary. The Eleventh Circuit's decision in this case stands alone in its holding, and is in conflict with decisions of this Court, and opinions of the other Courts of Appeals.

In a divided opinion, a two-judge majority of the Eleventh Circuit panel below held that an ERISA plan

administrator may insert a "choice of state law" clause into the last page of an SPD, effectively stripping the plan's participants and beneficiaries of the federal laws and protections that govern ERISA. Directly contradicting decisions of this Court, the Eleventh Circuit rested its holding on its erroneous conclusion that "private parties" may "contract out of" the federal law of ERISA.

In three material respects, the Eleventh Circuit Decision directly contravenes the precedent of this Court, other Circuit Courts, and Congress's intent in enacting ERISA. First, the Eleventh Circuit Decision directly contradicts this Court's holdings that private parties may ***not*** "contract around" the federal law that governs ERISA.

Second, the Eleventh Circuit Decision conflicts with the decisions of this Court and the other Courts of Appeals that the federal law of ERISA may not be replaced by state common law.

Third, the Eleventh Circuit Decision wrongly violates ERISA's widely-recognized, explicit goals of uniformity and protection of ERISA plan participants and beneficiaries.

No other Circuit Court that has addressed this issue has taken the position held by the Eleventh Circuit. Additionally, one of the three Eleventh Circuit Judges below explicitly declined to agree with the erroneous holding of the two-Judge majority.

The effect of the Eleventh Circuit Decision will be to create wide-spread disunity in ERISA law, as some plans will be governed by the federal law of ERISA, while others are subject to fifty-one sets of state common law doctrines. Furthermore, the Eleventh Circuit's decision wrongly fosters confusion

regarding the rights of ERISA plan beneficiaries and the obligations of ERISA fiduciaries. Accordingly, this Court should accept this petition and reverse the Eleventh Circuit's decision.

OPINIONS BELOW

The opinion of the Court of Appeals for the Eleventh Circuit, entered April 10, 2001, ___ F3d. ___, is reprinted in Appendix A. The Denial of Petitioner's Petition for Rehearing en Banc, entered by the Court of Appeals for the Eleventh Circuit on June 21, 2001, is reprinted in Appendix B. The decision of the U.S. District Court for the Northern District of Georgia, 74 F. Supp. 2d 1272, 1280 (N. D. Ga. 1999), entered on November 16, 1999, is reprinted in Appendix C.

JURISDICTION

The Order denying Petitioner's Petition for Rehearing en Banc was entered on June 21, 2001. This Court has jurisdiction under 28 U.S.C. §1254(1).

STATUTES INVOLVED

This case involves the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§1001-1461. 29 U.S.C. Sec. 1022 is reprinted in Appendix D.

STATEMENT OF THE CASE

1. Statement of Facts.

Petitioner Patricia W. Buce is the widow of Walter Howard Buce, Jr. Mr. Buce died from multiple burns that he suffered in a car crash on December 13, 1995. This case arises

from Mrs. Buce's claim for accidental death benefits that were part of an ERISA Plan offered by Mr. Buce's former employer, National Service Industries, Inc. ("NSI").

A. The Plan and the SPD Booklet.

Walter Buce enrolled in the NSI group Personal Accident Insurance Plan in 1985. (A-3). After enrolling in the NSI plan, Mr. Buce received a booklet entitled "Personal Accident Insurance Plan" (hereinafter referred to as "the Booklet"). (C-2).

As of April, 1985, the Plan was underwritten by Fireman's Fund. Respondent Allianz Life Insurance Company ("Allianz")(f/k/a North American Life and Casualty Company) assumed the policy in or around 1993. After Allianz assumed the policy, it published a revised Plan Booklet which included additional language. However, the revised Booklet was never issued to either Mr. Buce or Mrs. Buce. (C-3).

The entire 1985 Booklet cannot be classified as a Summary Plan Description. (C-2). Rather, the Booklet contained both the Summary Plan Description required under ERISA, as well as the Schedule of Insurance and the Certificate of Insurance. (C-2).

The topics addressed on Page One of the Booklet are "Eligibility" and "Enrollment." Page Two describes the "Death & Dismemberment Benefits."

Page Three explains "Disability Benefits." Page Three also lists four items under the heading "Exclusions." The four exclusions listed are injury or loss due to: (1) riding in an aircraft other than as a passenger for transportation; (2) suicide; (3) war; and (4) service in the armed forces. None of the listed

exclusions refer in any way to death in consequence of intoxication. (C-2). Rather, the only place an "intoxication" exclusion appears is within the Certificate of Insurance, which is not part of the SPD. (C-3).

Page Four of the Booklet addresses "Termination of Coverage" and "Conversion Privilege." Page Five explains "Filing a Claim" and "Claim Denial and Appeal." Page Six details "Cost" of premiums for varying levels of coverage.

The Schedule of Insurance is reprinted on pages Seven through Ten of the Booklet. The Certificate of Insurance is reprinted on pages Eleven through Thirteen.

Page Fourteen of the Booklet is entitled "Statement of Rights," which details the participant's rights and the Plan fiduciary's obligations under ERISA.

The last page of the Booklet, page Fifteen, contains the heading "Other Facts You Should Know." The sub-headings appearing on page Fifteen are "Plan Identification Numbers"; "Legal Matters" (listing the address of the NSI legal department); "Plan Administrator"; "Plan Continuance"; "Plan Funding"; "Plan Records"; and, finally, "Plan Documents."

The text that appears under "Plan Documents", the last sub-heading on the last page of the Booklet, behind the Certificate of Insurance and the Schedule of Insurance, reads as follows:

"Plan Documents: The insurance policy controlling the Plan's operation is summarized here in layman's language. The insurance policy is the legal instrument governing all benefits under the Plan. The Plan is to be interpreted in accordance with the laws of the State of Georgia. Booklets describing principal

provisions of the Plan have been issued and are available to any employee or employee's representative from local Personnel offices."

B. Mr. Buce's Death and Mrs. Buce's Claim for Benefits under the NSI Plan.

On December 13, 1995, Walter Buce died in a one-car accident while driving on Interstate 75 near Cleveland, Tennessee. Mr. Buce suffered fatal multiple third-degree burns when his car struck a guard rail, rolled over, and burst into flames. (C-2).

Mr. Buce's Death Certificate was issued by the Tennessee Department of Death. The only two causes of death given on the Death Certificate were (1) "Multiple Third Degree Burns" and (2)"Motor Vehicle Wreck with Conflagration." (C-2).

After Mr. Buce's accident, Mrs. Buce reviewed the Summary Plan Description. There is no exclusion in the SPD for "intoxication." Mrs. Buce did not have an autopsy performed, because none of the four (4) exclusions listed in the SPD would be affected by autopsy results. (C-15).

In January, 1996, Mrs. Buce timely filed her claim for benefits from the accidental death policy. NSI forwarded Mrs. Buce's claim to Appellant's third-party claims administrator, American Special Risk Management Corporation ("ASRM"). (C-3). ASRM denied Mrs. Buce's claim, asserting an "intoxication" exclusion that was not listed in the only SPD that the Buces ever received. (C-3).

Mrs. Buce timely appealed the denial of her claim for benefits. The insurer, Allianz, denied Mrs. Buce's appeal on

two inconsistent grounds. First, Allianz reiterated the "intoxication" exclusion that was plainly omitted from the only SPD that was ever given to Mr. Buce. Conversely, Appellant asserted that a heart attack, not alcohol, might have caused Mr. Buce's death. Relying on that speculative theory, Appellant asserted that Mr. Buce did not die from "bodily injury caused by an accident...and resulting directly and independently of all other causes." (C-4).

Like the intoxication exclusion, the definition which Respondent asserted to limit the term "accident" appears only in the Certificate of Insurance. The Certificate of Insurance states that "'Injury,' whenever used in this Certificate, means bodily injury caused by an accident occurring while the policy is in force as to the Insured Person and resulting directly and independently of all other causes in loss covered by the policy provided such injury is sustained under the circumstances and in the manner described in the Description of Hazards." (C-4).

In a letter communicating the insurance company's denial of Mrs. Buce's claim for benefits, the attorney for Allianz asserted that the term "accident", which appears only in the Certificate of Insurance, must be interpreted using the "accidental means" analysis. (A-8). The "accidental means" analysis has not been adopted as part of the federal common law that governs ERISA in the Eleventh Circuit (C-13, 14). Rather, it is a state common law doctrine that Allianz asserts should be applied in this case due to the reference to state law within the last paragraph of the last page of the SPD, under the sub-heading "Plan Documents."

C. Mrs. Buce's action against NSI and Allianz

After exhausting her administrative remedies, Mrs. Buce filed her Complaint against Allianz and NSI in the Superior

Court of Fulton County, Georgia, on December 11, 1997. (C-4).

Significantly, Allianz had the case removed to the United States District Court for the Northern District of Georgia, claiming that the case was preempted by federal law. Allianz cited the U.S. Supreme Court's decision in Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 at 56 (1987). (A-6).

Allianz and NSI filed a Motion for Summary Judgment in the District Court on November 20, 1998. On April 9, 1999, the District Court entered its Order denying the principal part of Defendants' Motion for Summary Judgment.

The District Court conducted the bench trial of this case on November 8 and 9, 1999. On November 18, 1999, the District Court entered its Order awarding judgment in favor of Mrs. Buce and against Allianz. No judgment was entered against NSI. (App. C).

In its Order, The District Court held that the "heightened arbitrary and capricious" standard of review should be applied in this case. Analyzing the first prong of the "heightened" standard, the District Court found that Mr. Buce's death from burns suffered in a car wreck is the quintessential "accident" under the general understanding of that term. The District Court also held that Allianz may not assert exclusions and limiting definitions which were not included within the only SPD that either Mr. or Mrs. Buce ever received. Id.

Based on these findings, the District Court held that Mrs. Buce had offered a "sufficiently sound" interpretation of the Plan to rival the insurance company's contrary determination, thereby satisfying the first prong of the heightened arbitrary and capricious standard of review. Id.

The District Court also found in Mrs. Buce's favor on the second prong of the heightened standard of review. Allianz failed to offer any evidence whatsoever to justify its denial on the basis of its benefit to all Plan participants and beneficiaries. As a result, the Court held that Allianz's denial of benefits was arbitrary and capricious, and that Mrs. Buce is entitled to the death benefit due under the Plan. Id.

The District Court rejected Allianz's argument that an ERISA case may be governed by a Georgia common law doctrine that has never been adopted as part of the federal common law that governs ERISA in the Eleventh Circuit. Accordingly, the District Court ordered that Allianz pay Mrs. Buce the benefits offered under the ERISA plan, plus interest and costs of litigation. Id.

Allianz appealed the District Court's decision to the Eleventh Circuit Court of Appeals. On April 10, 2001, the Eleventh Circuit's decision was entered. (App. A).

The Eleventh Circuit Decision correctly affirmed the District Court's finding that the "heightened arbitrary and capricious" standard of review should be applied in this case.

Nevertheless, the Eleventh Circuit Decision reversed the District Court's judgment in favor of Mrs. Buce. The Eleventh Circuit Decision incorrectly held that ERISA plan fiduciaries can "contract out" of the federal common law that Congress and the Courts have universally determined governs ERISA, thereby allowing Allianz to avoid paying Mrs. Buce's claim for plan benefits. A-30.

The Eleventh Circuit Decision rests on a factual assumption that is unsupported by the record in this case. Repeatedly, the Eleventh Circuit Decision wrongly asserts that

Walter Buce bargained for the specific provisions in the NSI accidental death benefit plan. (See, e.g., A-30). However, there is simply no evidence whatsoever to support the Eleventh Circuit Decision's assumption that Walter Buce had any opportunity to negotiate the terms of the NSI Plan. Rather, the District Court's factual finding is only that Mr. Buce "enrolled in NSI's optional Personal Accident Insurance Plan." R4-62 (emphasis added). The District Court's factual finding is not clearly erroneous and, therefore, must be upheld on appeal. See Horton v. Standard Life Ins. Co., 141 F.3d 1038 (11th Cir. 1998).

REASONS FOR GRANTING THE WRIT

THIS COURT MUST REVERSE THE INCORRECT ELEVENTH CIRCUIT DECISION BECAUSE STATE COMMON LAW CANNOT SUPPLANT THE FEDERAL LAW THAT GOVERNS ERISA.

I. THE ELEVENTH CIRCUIT'S DECISION DIRECTLY CONFLICTS WITH THIS COURT'S HOLDINGS THAT PARTIES CANNOT CONTRACT OUT OF FEDERAL ERISA LAW.

The majority in the Eleventh Circuit below pronounced that the pivotal issue decided in this case is "whether one can elect to contract around the substantive definitions for policy terms under the federal common law of ERISA." (A-46, fn. 4)(Barkett, C.J., concurring, joined by Pollack, D.J.).

The Eleventh Circuit's decision must be reversed because it directly contravenes this Court's holdings that ERISA plan fiduciaries ***cannot*** "contract out" of ERISA-based law. See Contract Pipe & Prods. v. Constr. Laborers Trust,

508 U.S. 602 (1993) and Connolly v. Pension Benefit Guaranty Corp., 475 U.S. 211 (1986).

Both Connolly and Concrete Pipe involved an amendment to ERISA that imposes "withdrawal liability" upon any employer that withdraws from a multiemployer plan. Id. Upon withdrawal from such a multiemployer ERISA plans, plan trustees sought to avoid withdrawal liability, asserting previous agreements with the plan participants to limit such liability. Id.

This Court flatly rejected the trustees' arguments that ERISA plan fiduciaries can "contract out" of the federal law that governs ERISA. This Court held that such an effort to avoid ERISA law "gains nothing from the fact" that the fiduciary "was protected by the terms of its contract from any liability beyond the specified" provision of its agreement. Id.

> "Contracts, however express, cannot fetter the constitutional authority of Congress. Contracts may create rights of property, but when contracts deal with a subject matter which lies within the control of Congress, they have a congenital infirmity. Parties cannot remove their transactions from the reach of dominant constitutional power by making contracts about them. If the regulatory statute is otherwise within the powers of Congress, therefore, its application may not be defeated by private contractual provisions."

Contract Pipe, 508 U.S. at 642 (emphasis added), quoting Connolly, supra. Moreover, this Court emphasized that "nothing has changed since these words were first written" in the case of Norman v. Baltimore & Ohio R. Co., 294 U.S. 240, 307-308 (1935). Id. at 643.

Even though there was no evidence that any of the NSI Plan's participants, including Walter Buce, ever saw or had the opportunity to "bargain for" the "choice of Georgia law" provision that is buried on the last page of the NSI Plan's SPD, the Eleventh Circuit erroneously held that private parties ***may*** "contract out" of the federal law that governs ERISA.

The Eleventh Circuit Decision wrongly contravenes this Court's decisions in Concrete Pipe and Connolly. Therefore, this Petition should be granted, and the Eleventh Circuit's incorrect decision should be reversed.

II. THE ELEVENTH CIRCUIT DECISION CONTRADICTS THE DECISIONS OF OTHER CIRCUIT COURTS OF APPEALS THAT PARTIES CANNOT CONTRACT OUT OF FEDERAL ERISA LAW.

One of the three Eleventh Circuit judges who considered this case below, Judge Carnes, expressly declined to join the majority's holding. Instead, Judge Carnes emphasized the decisions of the other Circuit Courts of Appeals, which "appear to have decided the issue differently." (A-31).

Specifically, the Courts of Appeals in the Seventh Circuit and the Eighth Circuit have both rejected the argument that plan fiduciaries may assert "choice of law" provisions to replace the federal common law that governs ERISA with a state's common law doctrines. Prudential Ins. Co. v. John Doe, 140 F.3d 785, 790-91 (8th Cir. 1998); Morton v. Smith, 91 F.3d 867, 671 (7th Cir. 1996). See also In re Sears Retiree Group Life Ins. Litig., 90 F.Supp. 2d 940, 950-51 (N.D. Ill. 2000).

In fact, not one federal circuit court has found that parties may "contract out" of the federal common law that governs ERISA, and replace it with the fifty states' varying common law doctrines. Because the Eleventh Circuit Decision is in direct conflict with the other circuit courts that have addressed this issue, as well as this Court's decisions in Connolly and Concrete Pipe, supra, this Court should accept this Petition and reverse the Eleventh Circuit's incorrect decision.

III. THE ELEVENTH CIRCUIT'S DECISION MUST BE REVERSED BECAUSE STATE COMMON LAW CANNOT DISPLACE ERISA FEDERAL LAW.

The Eleventh Circuit Decision turns on its incorrect holding that parties may "contract" to replace the federal law that governs ERISA with state law. However, both the Eleventh Circuit and this Court have already decided that state common law doctrines do not supercede the federal common law of ERISA. See, e.g., Cagle v. Bruner, 112 F.3d 1510 (11th Cir. 1997). Furthermore, the courts cannot create an exception to ERISA that Congress has not authorized. Accordingly, the Eleventh Circuit Decision should be reversed.

A. The Eleventh Circuit Decision directly conflicts with its own holdings that state common law doctrines cannot replace the federal common law of ERISA.

The Eleventh Circuit Decision should be reversed because it contradicts that court's own decisions that state common law doctrines cannot displace the federal law which

governs ERISA. See Kane v. Aetna Life Ins., 893 F.2d 1283, 1285 (11th Cir. 1990); Cagle v. Bruner, 112 F.3d 1510 (11th Cir. 1997)("this Court is not bound in ERISA cases by doctrines of state insurance law"); Garrison v. Northeast Georgia Medical Center, 66 F.Supp. 2d 1336 (N.D. Ga. 1999), aff'd., 211 F.3d 130 (11th Cir. 2000)(recognizing that "in contrast to" state regulations "which have been found to have a tenuous connection with employee benefit plans, the Supreme Court has found that state common law...claims against an insurance company based on the improper processing of benefits is preempted."); Garren v. John Hancock Mut. Life Ins. Co., 114 F.3d 21 (11th Cir. 1997)(holding that state common law "relates to" an ERISA benefit plan "for purposes of ERISA preemption whenever the alleged conduct at issue is intertwined with the refusal to pay benefits.").

These Eleventh Circuit decisions stem directly from this Court's holdings that federal courts, when reviewing decisions to deny ERISA beneficiaries' claims for benefits, must employ the "federal common law of rights and obligations under ERISA-regulated plans." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), citing Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 at 56 (1987); see also Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 24 n.26 (1983).

ERISA's legislative history shows that Congress explicitly intended that state common law would not supercede the federal common law of ERISA in actions brought by ERISA beneficiaries and participants. Dedeaux, 481 U.S. at 56. In Dedeaux, this Court stated that

> Congress's "expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop...would make little sense if the

> remedies available to ERISA participants and beneficiaries...could be supplemented or supplanted by varying state laws."

Id. (emphasis added).

State common law doctrines, including Georgia's "accidental means" analysis, may be considered in an ERISA action only when the federal courts have adopted such a state common law principle into the federal common law that governs ERISA in that circuit. See id.; see also Glass v. United of Omaha Life Ins. Co., 33 F.3d 1341 (11th Cir. 1994). However, ***no decision*** in the Eleventh Circuit, ***including*** the opinion in this case, has adopted the widely-criticized common law "accidental means" analysis into the ERISA common law of the Eleventh Circuit. The Eleventh Circuit Decision incorrectly replaced federal ERISA law with the state law "accidental means" analysis in order to reverse the District Court's correct holding, without adopting that analysis within the federal common law of ERISA in the Eleventh Circuit. Accordingly, this petition should be granted, and the erroneous decision below should be reversed. See id.

B. The Eleventh Circuit Decision Cannot Stand Because Congress Has Not Created Any Exception That Allows Parties to Replace the Federal Law that Governs ERISA with State Law Doctrines.

The erroneous decision below must be reversed because Congress has not enacted any provision within ERISA that would allow Allianz to contract around the federal law that governs ERISA. "The identification of any exception (to ERISA law) should be left to Congress." Guidry v. Sheet Metal

Workers Nat'l. Pens. Fund, 493 U.S. 365 (1990); see also Mass. Mut. Life Ins. Co v. Russell, 473 U.S. 134, 147 (holding that a cause of action for punitive damages arising from breach of fiduciary duties cannot be inferred under ERISA, because "the presumption that a remedy was deliberately omitted from a statute is strongest when Congress has enacted a comprehensive legislative scheme including an integrated system of procedures for enforcement."); American Airlines, Inc. v. Wolens, 513 U.S. 219 (1995)(citing Dedeaux, 481 U.S. at 54 (1987) and Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 143-145 (1990) in holding that the federal Airline Deregulation Act "contrasts markedly with the ERISA, which does channel civil actions into federal courts, under a comprehensive scheme, detailed in the legislation, designed to promote prompt and fair claims settlement.").

Like this Court, the Eleventh Circuit has recognized that only Congress may create exceptions to ERISA's preemption of state common law doctrines. Garrison v. Northeast Georgia Medical Center, supra. In Garrison, the plaintiff's state common law claims were dismissed because the federal courts are "bound by Congress' broadly worded preemption clause and the limited remedies under ERISA for claimants. It is within Congress' province to alter this result, if they should so desire." Id. Because Congress has not authorized private parties to replace the federal law that governs ERISA with fifty (50) varying sets of state common law doctrines, this Court should find that the Eleventh Circuit Decision must be reversed. See id.

IV. THE ELEVENTH CIRCUIT'S DECISION THREATENS ERISA'S WELL-ESTABLISHED GOALS

It is well-established that "ERISA has two central goals: (1) protection of the interests of employees and their beneficiaries in employee benefit plans; and (2) uniformity in the administration of employee benefit plans." Horton v. Standard Life Ins. Co., 141 F.3d 1038 (11th. Cir. 1998). The Eleventh Circuit Decision should be reversed because it contravenes the well-established goals of ERISA.

A. The Eleventh Circuit Decision Undermines Uniformity in ERISA Cases.

ERISA's mandate that federal law govern ERISA actions "was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefit law." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 143-145 (1990). Application of state common law doctrines in only some ERISA actions, depending on the terms of individual plan descriptions, undermines that goal.

> "Particularly disruptive is the potential for conflict in substantive law. It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement." Id.

This Court reiterated these concerns in its very recent decision in Egelhoff v. Egelhoff, 69 U.S.L.W. 4206 (March 21,

2001). "One of the principal goals of ERISA is to enable employers to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Uniformity is impossible, however, if plans are subject to different legal obligations in different States."

"Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of minimizing the administrative and financial burdens on plan administrators - burdens ultimately borne by the beneficiaries." Id. "We recognize that all state laws create some potential for a lack of uniformity. But differing state regulations affecting an ERISA plan's system for processing claims and paying benefits impose precisely the burden that ERISA pre-emption was intended to avoid." Id.

Here, the District Court recognized that Georgia's common law "accidental means" analysis is ***not*** part of the federal common law that governs ERISA in this Circuit. (C-13, 14). Subsequently, the Eleventh Circuit did ***not*** adopt the Georgia "accidental means" analysis as part of the federal common law that governs ERISA in this Circuit.

Rather, following the Eleventh Circuit's decision in this case, the "accidental means" analysis may only be applied in those cases where the parties have supposedly "contracted" for state law to supercede federal ERISA law.

As this Court has recognized in other cases, one can easily foresee the untenable result of the Eleventh Circuit's decision in this case. ERISA's goal of uniformity will be circumvented if a plan participant or beneficiary has one ERISA

plan that purports to be governed by state law, but his or her other ERISA plans are governed by the federal law of ERISA.

Furthermore, confusion and increased litigation will result from the Eleventh Circuit Decision's failure to set any parameters for the application of "state law" in ERISA cases. Exactly which "state laws" should be applied to such an ERISA plan? If, as the Eleventh Circuit decided, this is a "Georgia benefits plan" (A-31), why was Allianz able to avoid the state law claims that Mrs. Buce originally asserted?

The result of the Eleventh Circuit Decision can only be confusion among ERISA participants and beneficiaries, not to mention the various district courts in the various states in this Circuit, as to which state common law doctrines would be applicable, and which would not, in cases such as this. Accordingly, this Court should grant this Petition, and find that the Eleventh Circuit Decision impermissibly undermines ERISA's goal of uniformity.

B. Denying Claims for ERISA Benefits Based on State Common Law Doctrines that are Not Part of the Federal Common Law of ERISA Violates ERISA's Goal of Protecting Plan Participants and Beneficiaries.

The Eleventh Circuit has recognized that "[a] central policy goal of ERISA is to protect the interests of employees and their beneficiaries in employee benefit plans." Nachwalter v. Christie, 805 F.2d 956, 959-60 (11th Cir. 1986). "Congress wanted to assure that those who participate in [ERISA-governed] plans actually receive the benefits they are entitled to." Helms v. Monsanto Co., 728 F.2d 1416, 1420 (11th Cir. 1984).

Congress requires ERISA fiduciaries to provide ERISA plan participants and beneficiaries with an SPD that fully and fairly apprises them of their rights under ERISA. See 29 U.S.C. § 1022(a) ("The summary plan description ... shall be sufficiently accurate and comprehensive to reasonably apprise ... participants and beneficiaries of their rights and obligations under the plan."); 29 C.F.R. §2520.102-2(a). It defies comprehension and common sense for any court to hold that, by burying a single "choice of state law" sentence within the last paragraph of the last page of an SPD booklet, under the sub-heading "Plan Documents", an ERISA fiduciary has fairly apprised a non-lawyer plan participant or beneficiary that their rights under the federal law of ERISA have been decimated.

The Eleventh Circuit unquestionably violated the NSI plan's participants' and beneficiaries' rights under ERISA by deciding that benefits may be denied pursuant to state common law that is not and never has been incorporated into the federal common law of ERISA in the Eleventh Circuit. "To decide whether a particular rule should become part of ERISA's common law, courts must examine whether the rule, if adopted, would further ERISA's scheme and goals." Horton, supra. The Eleventh Circuit below failed to conduct such an inquiry, but instead decided that state law should completely displace the federal law of ERISA in this case. The Eleventh Circuit's decision countenances the eradication of rights conferred upon all ERISA plan participants and beneficiaries, and should be reversed.

Further, the Eleventh Circuit's decision wrongly allows an insurance company like Allianz to rely on state law to deny claims, even though the beneficiary is precluded from asserting state claims against the insurer. Both this Court and the Eleventh Circuit have consistently held that an ERISA plan participant or beneficiary cannot assert state law claims against

an ERISA fiduciary. See, e.g., Clark v. Coates & Clark, Inc., 865 F.2d 1237 (11th Cir. 1989); Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987). It is both fundamentally unfair and totally inconsistent with ERISA's stated goal of protecting plan participants and beneficiaries for an insurer to be able to use ERISA preemption as a shield from state law claims, but then use the Eleventh Circuit Decision in this case to wield state law as a sword to deny a plan beneficiaries' claim for benefits.

That is exactly what happened in this case. Due to the confusing reference to Georgia law in the NSI Plan's Summary Plan Description, Mrs. Buce originally filed her Complaint in this case in the Superior Court of Fulton County. The Complaint alleged both state law claims and violations of ERISA. However, Allianz immediately had the case removed to the District Court. Citing Pilot Life Insurance Co. v. Dedeaux, supra, Allianz explicitly stated that Mrs. Buce's claims were preempted by ERISA.

It is fundamentally unfair and contrary to the policy goals of ERISA for Allianz to be able to use ERISA's federal structure as a shield from Mrs. Buce's state law claims, but then get permission from a Circuit Court of Appeals, standing alone, to substitute state law for the federal law of ERISA in order to avoid paying Mrs. Buce's claim for ERISA benefits. Because the Eleventh Circuit Decision eviscerates the widely-recognized goals of ERISA, this Court should grant this petition and reverse the incorrect Eleventh Circuit Decision.

CONCLUSION

The Eleventh Circuit Decision directly conflicts with this Court's decisions (as well as the decisions of the other Circuit Courts of Appeals that have considered this issue) that ERISA

fiduciaries cannot "contract out" of the federal law that Congress decided should govern ERISA.

Additionally, the Eleventh Circuit's decision is contrary to the law and the intent of ERISA because it opens the door for insurance companies (like Allianz) and other ERISA fiduciaries to "opt out" of the federal law that governs ERISA in favor of state common law doctrines that are ***not*** part of the ERISA federal law in order to avoid paying claims made by ERISA plan participants and beneficiaries.

For these reasons, this Petition should be granted and the Eleventh Circuit's incorrect decision should be reversed.

Respectfully submitted,

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APPENDICES

APPENDIX "A"

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

FILED
U.S. COURT OF APPEALS
ELEVENTH CIRCUIT
APR 10, 2001
THOMAS K. KAHN, CLERK

No. 99-15405

D. C. Docket No. 98-00112-CV-TWT

PATRICIA W. BUCE,

Plaintiff-Appellee,

versus

ALLIANZ LIFE INSURANCE COMPANY f.k.a. North American Life and Casualty Company,

Defendant-Appellant.

Appeal from the United States District Court
for the Northern District of Georgia
(April 10, 2001)

Before CARNES and BARKETT, Circuit Judges, and POLLAK*, District Judge.

*Honorable Louis H. Pollak, U.S. District Court for the Eastern District of Pennsylvania, sitting by designation.

POLLAK, District Judge:

This appeal presents questions arising from the denial - initially by the plan administrator and then by the insurance carrier - of death benefits claimed under an employer-sponsored personal injury insurance policy governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 et seq. On "heightened arbitrary and capricious" review by the District Court, the denial of benefits was overturned and the plaintiff - the widow of the decedent - was awarded $150,000, the face amount of the policy. On appeal to this court, the insurance carrier contends that the District Court erred, under ERISA, (1) in its rejection of the carrier's interpretation of the policy term "bodily injury caused by an accident ... and resulting directly and independently of all other causes in loss covered by the policy" as applied to the facts of the decedent's death, and (2) in its rejection of the carrier's reliance on the policy's intoxication exclusion provision as an alternative ground for denial of the claimed benefits. The insurance carrier also argues that the proper standard of District Court review of the denial of benefits was not "heightened arbitrary and capricious" but "arbitrary and capricious."

In Part I of this opinion we outline the principal facts giving rise to the plaintiff s claim and the manner in which the claim was addressed by, first, the plan administrator and, second, the insurance carrier. In Part II, we summarize the history of the case after it came to court - first, a Georgia state court and then, on removal, the District Court. In Part III we consider the contentions made by the insurance carrier on appeal.

I.

Walter H. Buce, Jr., a Georgia resident, was employed by National Services Industries, Inc. ("NSI"), a company located in Atlanta. In 1985 Mr. Buce elected to become insured under a group Personal Accident Insurance Plan provided by NSI as an optional employee benefit. The accident insurance plan - originally underwritten by Fireman's Fund, Inc., but taken over, in 1993, by Allianz Life Insurance Company of North America ("Allianz") - provided that: "The Plan is to be interpreted in accordance with the laws of the State of Georgia." On December 13, 1995, at about 2:00 a.m., Mr. Buce, was killed in a single-vehicle crash on Interstate 75 near Cleveland, Tennessee. There were no passengers or other witnesses. A posthumously drawn blood sample measured Mr. Buce's alcohol level as .22 percent.

Mr. Buce's widow, Patricia W. Buce, the beneficiary of her husband's accident policy, filed a claim. NSI, Mr. Buce's employer, referred the claim to Allianz, the insurance carrier. Allianz in turn referred the claim to American Special Risk Management ("ASRM"), the company retained by Allianz to act as administrator of the insurance plan; as of that time, Allianz was ASRM's sole client.

On March 12, 1996, ASRM, in a letter written by its Claims Director, Edward F. Carroll, denied Mrs. Buce's claim. The substance of Mr. Carroll's decision was as follows:

> "This Policy provides a "Loss of Life Accident Indemnity. When injury results in the loss of life of the Insured Person". The Policy also states the following:

20. The Company shall not be liable for any loss sustained in consequence of the person whose injury is the basis of a claim being intoxicated or under the influence of any narcotic unless administered on the advise [sic] of a physician.

We have obtained the Cleveland Police Department report that indicated this single car accident happened when the car "left the roadway on the right hand shoulder of the road striking the guard rail". The Tennessee Bureau of Investigation's Forensic Services Crime Laboratory report on Alcohol, indicated the insured's level was twice the legal limit permitted to operate a vehicle. We therefore, must deny any Accidental Death Benefits for this accident, under the terms of this policy."

Mrs. Buce's attorney, John E. Robinson, took issue with Mr. Carroll's decision in a letter dated May 9, 1997. Mr. Robinson's letter was referred to Douglas Campbell, Allianz's attorney. On July 11, 1997 Mr. Campbell wrote to Mr. Robinson reaffirming the denial of Mrs. Buce's claim:

"This Firm represents Allianz Life Insurance Company of North America [the "Company"] and your letter of May 9, 1997, regarding the above referenced claim has been referred to us for response ....

[T]he Company has, at your request, re-evaluated this claim and the materials you have submitted in support thereof. This is an accident policy which, as applicable to this particular claim, provides payment of benefits where loss of life is due to bodily injury caused by an accident and resulting directly and

independently of all other causes in death. As such, it is an "accidental means" policy which requires that, in the act which preceded the injury, there must have occurred something sudden, unexpected and unforeseen. In the first instance, the materials you have submitted do not show any positive identification of the individual found in the wrecked automobile as in fact being Mr. Buce, even though the death certificate states that it was. Moreover, even if the body was that of Mr. Buce, tests revealed that, several hours after the wreck, there was present a blood alcohol level of .22%, which would mean that Mr. Buce was intoxicated at the time of the wreck. Given the weather and road conditions as reported by the authorities, and the lack of any evidence of vehicular malfunction, it appears that Mr. Buce's injuries were occasioned by his voluntary ingestion of alcohol and were therefore not "bodily injuries cause [d] by an accident" as required by the coverage provisions of the Policy.

Furthermore, the Policy contains the following exclusion:

20. The Company shall not be liable for any loss sustained in consequence of the person whose injury is the basis of claim being intoxicated ...

As the Policy contains no definition of intoxication, the common law definition would apply - namely, that the person was materially impaired from guarding himself against casualty or injury. A person with a .22% (or higher at the time of the wreck) blood alcohol level is undoubtedly materially impaired within the meaning of that definition. As discussed in the

preceding paragraph, it was this impairment which caused the wreck that resulted in Mr. Buce's death.

For the foregoing reasons, and based entirely on the information available to us at this time, including the information you submitted in support of the claim, the Company, upon reconsideration, again denies the claim."

On December 5, 1997, in response to a further letter from Mr. Robinson, Debra Libby, NSI's Assistant Counsel, stated that "we regret that this unfortunate event occurred, but the claim does not appear to be covered by the Plan."

II

Six days later - on December 11, 1997 - Mrs. Buce filed this law suit, naming as defendants NSI, ASRM and Allianz (the latter was originally sued under its former name,, North American Life and Casualty Company). Suit was brought in the Superior Court of Fulton County, Georgia. Invoking ERISA, the defendants removed the case to the United States District Court for the Northern District of Georgia.

After granting in part and denying in part motions for summary judgment filed by the defendants, the District Court conducted a two-day bench trial. Shortly thereafter, the District Court filed its opinion awarding judgment in Mrs. Buce's favor, against Allianz, for the policy proceeds of $150,000, plus prejudgment and postjudgment interest. "The denial of benefits was arbitrary and capricious," the District Court ruled, and the Plaintiff is entitled to the death benefit due under the Plan." Buce v. National Services Industries, Inc., et al., 74 F. Supp. 2d

1272, 1280 (N. D. Ga. 1999). Finding no "breach of fiduciary duty," id., on the part of ASRM and NSI, the District Court directed the entry of judgment in favor of those defendants.

In ruling against Allianz, the District Court came to a series of conclusions:

(A) The first issue addressed by the District Court was the standard of review under which it was to judge the correctness of Allianz's denial of benefits. The District Court noted that the Supreme Court, in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989), had held that "a denial of benefits challenged under [29 U.S.C.] § 1132(a)(1)(B) is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan .... Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" In the case at bar, the District Court found that de novo review was not an option, since the policy's Summary Plan Description provided that "[t]he insurance company has the exclusive right to interpret the provisions of the Plan, so its decision is conclusive and binding." 74 F.Supp. 2d at 1275. The District Court pointed out, however, that, in conformity with Firestone's admonition about conflicts of interest, the very deferential "arbitrary and capricious" standard requires modification where the insurance carrier is the effective decision-maker. As the District Court observed, this court has had several occasions to address this problem, most notably in Brown v. Blue Cross and Blue Shield of Alabama, Inc., 898 F. 2d 1556, cert. denied, 498 U.S. 1040 (1991), and Buckley v. Metropolitan Life, 115 F. 3d 936 (11 th Cir. 1997). In Buckley, so the District Court noted, we said the less deferential "heightened arbitrary and capricious standard

must be used when the plan was administered by an insurance company which paid benefits out of its own assets." 115 F. 3d at 93 9. Applying these teachings to the role of Allianz in relation to Mrs. Buce's claim, the District Court concluded that the case before it was controlled by Brown v. Blue Cross and Blue Shield of Alabama, Inc. "There, Blue Cross determined whether it would pay benefits from its own coffers - an inherent and obvious conflict of interest. The situation here differs only slightly with ASRM evaluating Plaintiff s claim for its only client and then a final decision by Allianz. Therefore, the Court may review the determination of benefits under the heightened arbitrary and capricious standard." 74 F. Supp. 2d at 1276. The impact of this ruling was, according to the District Court, that: "First, the Court must determine whether under a de novo review Plaintiff has offered a sufficiently sound interpretation of the disputed plan provision to rival the Defendants' contrary determination .... Second, the Court must determine whether the fiduciary's adoption of the different interpretation was 'arbitrary and capricious.'" Id.

(B) Mr. Buce's policy provided coverage for "bodily injury caused by an accident ... and resulting directly and independently of all other causes in loss covered by the policy." In the July 11, 1997 letter of Allianz's attorney, reaffirming the denial of Mrs. Buce's claim, the carrier's position was that "[t]his is an accident policy which, as applicable to this particular claim, provides payment of benefits where loss of life is due to bodily injury caused by an accident and resulting directly and independently of all other causes in death. As such, it is an 'accidental means' policy which requires that, in the act which preceded the injury, there must have occurred something sudden, unexpected and unforeseen .... [I]t appears that Mr. Buce's injuries were occasioned by his voluntary ingestion of alcohol and were therefore not 'bodily injuries cause[d] by an accident' as required by the coverage provisions of the Policy."

The District Court discussed the legal sufficiency of the carrier's position as follows:

> "The first question to be addressed is whether the insurance company properly interpreted the Plan by reading into the policy an exclusion for injury or death that is foreseeable based upon such risk increasing behavior as driving while intoxicated. In Laney v. Continental Ins. Co., 757 F.2d 1190 (11th Cir. 1985), the Eleventh Circuit addressed this issue in the context of a diversity case applying Georgia law. The decedent in that case died of acute alcohol poisoning; the autopsy showed a blood alcohol content of .47 grams percent. The court recognized that Georgia law distinguishes between the terms "accidental injury" and "injuries resulting from accidental means. " Id. at 119 1. Applying Georgia law, the court concluded that "caused by accident" is synonymous with "accidental means." Id. at 1192. "The focus is on the occurrence or happening which produces the result, not the result itself" Id. The court then concluded:
>
> "Given this construction of the policy term, it is evident that the defendant was entitled to judgment as a matter of law. Mrs. Laney does not dispute that her husband intentionally and voluntarily drank the alcohol that caused his death. Nor does she contend that some mischance, slip or mishap occurred during his consumption of the whiskey and beer to cause him to consume more than he intended. Although the result of his drinking was unexpected, the act of drinking was intentional. Georgia law makes it clear that such conduct is not covered by an "accidental means" policy."

Id. See also Continental Assurance Company v. Rothell, 227 Ga. 258, 181 S.E.2d 283 (1971). A reasonable person would have foreseen that driving with a blood alcohol level of .22 grams percent was highly likely to result in injury or death. If Laney or Georgia law applies to this case, the court should enter judgment in favor of the Defendants and against the Plaintiff. Nevertheless, it is also unquestionably true that the ordinary purchaser of an accidental death insurance policy would think that the unintentional and unexpected burning, to death as a result of a car wreck constitutes death by accident.

The Eleventh Circuit has clearly held that ERISA preempts state law and authorizes federal courts to create federal common law to implement Congress' statutory scheme. Branch v. G. Bernd Co., 955 F.2d 1574, 1580 (11th Cir. 1992). In this case, the Court is faced with the question of whether to frustrate the statutory scheme of ERISA by adhering to the metaphysical distinction between "accidental means" and "accidental results" that has bedeviled the courts for more than 60 years ....

... The Eleventh Circuit has clearly stated the process for determining ERISA common law.

"To decide whether a particular rule should become part of ERISA's common law, courts must examine whether the rule, if adopted, would further ERISA's scheme and goals. ERISA has two central goals: (1) protection of the interests of employees and their beneficiaries in employee benefit plans; and (2) uniformity in the administration of employee benefit plans." Horton v. Reliance Standard Life Ins. Co.,

> 141 F.3d 1038, 1041 (11th Cir. 1998) (citations omitted). Reading a foreseeability exclusion into the policy would frustrate the Congressional purpose of protecting ERISA plan beneficiaries. It would not contribute to uniformity in the administration of employee benefit plans. A foreseeability exclusion contributes to uncertainty and difficulty of administration. "[A]n insured should not have to consult a long line of case law or law review articles and treatises to determine the coverage he or she is purchasing under an insurance policy."

74 F. Supp. 2d at 1276, 1279.

Accordingly, the District Court concluded "that Allianz applied an incorrect legal standard to the determination of whether Mr. Buce died as a result of an accident." Id. at 1279.

(C) Finally, the District Court rejected Allianz's alternative contention that Mrs. Buce's claim was, in any event, barred by the policy's intoxication exclusion provision, which read: "The Company shall not be liable for any loss sustained in consequence of the person whose injury is the basis of claim being intoxicated or under the influence of any narcotic unless administered on the advice of a physician." The District Court found that the 1985 Summary Plan Description, a portion of a plan booklet furnished to Mr. Buce, "contained a list of policy exclusions that did not include an exclusion for injuries due to intoxication." Id. The 1993 plan booklet contained a Summary Plan Description which did include an intoxication exclusion provision, but the District Court found, on the basis of NSI's answers to interrogatories, that "the 1985 Summary Plan Description was the only one ever issued to either Mr. or Mrs. Buce, id. at 1274, with the result that the 1985 Summary Plan Description was to be treated as the operative one. And as

between the 1985 Summary Plan Description and the text of the policy, the District Court, citing our decision in McKnight v. Southern Life and Health Ins. Co., 758 F. 2d 1566, 1570 (11th Cir. 1985), concluded that "[w]hen a summary plan document conflicts with the plan, the summary controls." Id. at 1279.

III

On appeal, Allianz challenges each of the District Court's rulings.

The first ruling - that "heightened arbitrary and capricious" review is the proper standard for federal court review of the benefits denial in this case - is, as a matter of law, unassailable, for the reasons cogently stated by the District Court. ASRM - the plan administrator, and author of the initial denial of Mrs. Buce's claim - was dependent on the patronage of Allianz. And on review of ASRM's decision, Allianz, in stating through its attorney in the July 11, 1997 letter, that it "ha[d] ... reevaluated this claim, was exercising its ultimate authority to determine for itself whether payments should be made out of its own assets - an authority which then led it, "upon reconsideration," to conclude that it "again denies the claim." This is precisely the conflict-of-interest setting which - under this court's case law, carefully analyzed by the District Court - calls for "heightened arbitrary and capricious" review.

In its opening brief on appeal, Allianz undertakes to deflect the District Court's exercise of "heightened arbitrary and capricious" review by arguing that "notwithstanding a conflict of interest, the heightened arbitrary and capricious test does not apply if the administrator's interpretation of the plan language is correct." We think, however, that it is not the correctness of the administrator's interpretation - namely, that the intoxication exclusion barred Mrs. Buce's claim - which is chiefly at issue.

We think, rather, that what is chiefly at issue is the correctness of the insurance carrier's interpretation, for that was the final and controlling rationale for the denial of benefits. To be sure, the insurance carrier did invoke the intoxication exclusion provision, but that ground was alternative, and ancillary, to its principal basis for denying Mrs. Buce's claim - namely, that Mr. Buce's policy was "an 'accidental means' policy which requires that, in the act which preceded the injury, there must have occurred something sudden, unexpected and unforeseen," and that "Mr. Buce's injuries were occasioned by his voluntary ingestion of alcohol and were therefore not 'bodily injuries cause[d] by an accident' as required by the coverage provisions of the Policy." The District Court, in the second of its three rulings, rejected that interpretation, holding that "accidental means" doctrine, while good law in Georgia, was not a permissible ingredient of a benefits plan governed by ERISA. To the correctness of that ruling, which is subject to plenary review by this court, we now turn.

The District Court, in the portion of its analysis quoted above (in Part II(B) of this opinion), noted that Georgia is an "accidental means" jurisdiction, as recognized by this court in Laney v. Continental Ins. Co., 757 F. 2d 1190 (11th Cir. 1985), and went on to observe that "[i]f Laney or Georgia law applies to this case, the Court should enter judgment in favor of the Defendants and against the Plaintiff." 74 F. Supp. 2d at 1276. However, the District Court, finding limited value in "accidental means" doctrine, concluded that, since the case at bar is not, like Laney, a diversity case, but an ERISA case, the Georgia law of "accidental means" was not controlling. Specifically, the District Court ruled - correctly - that when a federal court construes an ERISA-regulated benefits plan, the federal common law of ERISA supersedes state law. See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56 (1987); Horton v. Reliance Standard Life Ins. Co., 141 F.3d 1038, 1041 (11th Cir. 1998);

Todd v. AIG Life Ins. Co., 47 F. 3d 14485 1451 (5th Cir. 1995). Finding "accidental means" doctrine to be incompatible with "the developing ERISA federal common law," 74 F. Supp. 2d at 1278, the District Court held that "it is arbitrary and capricious for an insurer to deny a claim based upon an interpretation of 'accident' that is not stated in the policy and that is contrary to the expectations of the ordinary insured." Id. at 1279.

In the portion of the District Court's opinion quoted at some length in Part II(B) of this opinion, supra, the District Court referred to "the metaphysical distinction between 'accidental means' and 'accidental results' that has bedeviled the courts for more than 60 years." The "more than 60 years" was a reference back to the Supreme Court's decision in Landress v. Phoenix Ins. Co., 291 U.S. 491 (1934). Landress was a pre-Erie[1] diversity case. The decedent died of sunstroke while playing golf The decedent's widow sought to recover on two accident insurance policies. One policy provided coverage for death resulting "directly and independently of all other causes from bodily injuries effected through external, violent and accidental means, and not directly or indirectly, wholly or partly from disease or physical or mental infirmity." The other policy provided coverage for death resulting "from bodily injuries effected directly and independently of all other causes through external, violent and accidental means." On certiorari, the Court reviewed a judgment of the Sixth Circuit, 65 F. 2d 232, affirming the district court's dismissal of the complaint. The Court affirmed Speaking through Justice Stone, the Court explained:

1

1 Erie R. Co. v. Tompkins, 304 U.S. 64 (1938).

"Petitioner argues that the death, resulting from voluntary exposure to the sun's rays under normal conditions, was accidental in the common or popular sense of the term and should therefore be held to be within the liability clauses of the policies. But it is not enough, to establish liability under these clauses, that the death or injury was accidental in the understanding of the average man - that the result of the exposure "was something unforeseen, unsuspected, extraordinary, an unlooked for mishap, and so an accident," see Lewis v. Ocean Accident & G. Corp., 224 N.Y. 18, 21; see also Aetna Life Ins. Co. v. Portland Gas & Coke Co., 229 Fed. 552 - for here the carefully chosen words defining liability distinguish between the result and the external means which produces it. The insurance is not against an accidental result. The stipulated payments are to be made only if the bodily injury, though unforeseen, is effected by means which are external and accidental. The external means is stated to be the rays of the sun, to which the insured voluntarily exposed himself. Petitioner's pleadings do not suggest that there was anything in the sun's rays, the weather or other circumstances, external to the insured's own body and operating to produce the unanticipated injury, which was unknown or unforeseen by the insured ....

This distinction between accidental external means and accidental result has been generally recognized and applied where the stipulated liability is for injury resulting from an accidental external means .... And injury from sunstroke, when resulting from voluntary exposure by an insured to the sun's rays, even though an accident, see Ismay, Imrie & Co., v.

Williamson [1908] A.C. 437, has been generally held not to have been caused by external accidental means."

291 U.S. at 495-96.

Justice Cardozo dissented. "A cause," he wrote, "does not cease to be violent and external because the insured has an idiosyncratic condition of mind or body predisposing him to injury .... Here the complaint alleges that the idiosyncrasy was not a physical or mental disease, and that it appeared from autopsy that there was no bodily infirmity or disease which could have been a contributing cause of death. Since the case is here on demurrer, those allegations must be taken as true." Id. at 498. Cardozo then turned to the contending legal principles as they applied to the case before the Court:

> "2. Sunstroke, though it may be a disease according to the classification of physicians, is none the less an accident in the ordinary speech of men .... The suddenness of its approach and its catastrophic nature . . . have made that quality stand out when thought is uninstructed in the mysteries of science .... Violent it is for the same reason, and external because the train of consequences is set in motion by the rays of the sun beating down upon the body, a cause operating from without.
>
> In my view this man died from an accident. What killed him was a heat-stroke coming suddenly and unexpectedly upon him while at work. Such a stroke is an unusual effect of a known cause, often, no doubt, threatened, but generally averted by precautions which experience, in this instance, had not taught. It was an unlooked for mishap in the course of his employment. In common language, it was a case of

accidental death." Per Loreburn, L. C., in Ismay, Imrie & Co., v. Williamson, supra.

3. The attempted distinction between accidental results and accidental means will plunge this branch of the law into a Serbonian Bog. "Probably it is true to say that in the strictest sense and dealing with the region of physical nature there is no such thing as an accident." Halsbury, L. C., in Brinton's v. Turvey, L.R. [1905] A.C. 230, 233... On the other hand, the average man is convinced that there is, and so certainly is the man who takes out a policy of accident insurance."

Id. at 498-99.

In Landress Cardozo stood alone. His elegant, ominous and obscure warning of the menace that lurked in a Serbonian Bog - a type of bog not locatable in Black's Law Diction or in Words and Phrases[2] - was lost on his colleagues. But in

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2

"Serbonian Bog" is "[John] Milton's name for Lake Sarbonis in Lower Egypt, a marshy tract (now dry) covered with shifting sand. Hence used allusively." II The Compact Edition of the Oxford English Diction 2735 (Oxford University Press 1971). Milton's reference to the Bog appears in the sentence that comprises lines 587-95 of Book II of Paradise Lost:

Beyond this flood a frozen Continent
Lies dark and wilde, beat with perpetual storms
Of Whirlwind and dire Hail, which on firm land
Thaws not, but gathers heap, and ruin seems

subsequent decades many state courts - a number of them clearly influenced by Cardozo's gloomy admonition (e.g., the Colorado Supreme Court, per Chief Justice Burke: "[W]hatever kind of bog that is, we concur," Equitable Life Assur. Soc. v.Hemenover, 67 P. 2d 80, 81 (Colo. 193 7)) - have tended to collapse "accidental means," "accident," "accidental result," "accidental injury," "accidental death," and other formulations into a unitary legal concept pursuant to which "the term 'accidental' is equally descriptive of means which produce effects which are not their natural and probable consequences, as it is of means which are wholly unexpected." Lee R. Russ & Thomas F. Segalla, 10 Couch on Insurance 3d §139:22 (1998 ed.).

As of today, the jurisdictions, of which Georgia is one, that continue to adhere to "accidental means" as a category of accident insurance liability distinct from, and more restrictive

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> Of ancient pile; all else deep snow and ice,
> A gulf profound as that *Serbonian* Bog
> Betwixt *Damiata* and mount *Casius* old,
> Where Armies whole have sunk: the parching Air
> Bums frore, and cold performs th' effect of Fire.

The Poetical Works of John Milton, 215 (W. Skeat ed., Oxford University Press, 1938).

It appears that insurance law is not the only legal realm that may have within its confines a Serbonian Bog. See Texas v. Cobb, 532 U.S. _ (April 2, 2001), in which Justice Breyer, in dissent, characterized a constitutional test adopted by the Court, in overturning the Texas Court of Criminal Appeals' reversal of a murder conviction, as so amorphous as to be likely to prove "the criminal law equivalent of Milton's 'Serbonian Bog ... Where Armies whole have sunk.'" Id. at __.

than, other categories of accident insurance liability are in the minority. Id. at §139:21. But it does not seem to be a small minority. In 1994, the California Supreme Court, in a lengthy opinion by Justice George announcing (over vigorous dissent) continued allegiance to "accidental means," noted that, "as of 1992, 22 jurisdictions, including California, expressly recognized the distinction between 'accidental means' and 'accidental death' (3 Harnett & Lesnick, [The Law of Life and Health Insurance], §7.03[l], pp. 7-24-7-29; id., (1992 supp.) p. 5), whereas 25 jurisdictions expressly have rejected or repudiated this distinction. (3 Harnett & Lesnick, supr., §7.06[l], pp.7-112-7-116)." Weil v. Federal Kemper Life Assurance Co., 866 P. 2d 774, 781 (Cal. 1994).[3] Justice George also noted that the First Circuit, in an ERISA case - Wickman v. Northwestern Nat. Ins. Co., 908 F. 2d 1077 (1 st Cir.), cert. denied, 498 U.S. 10 13 (1990) - had rejected "accidental means."

In Wickman, the decedent, Paul Wickman, fell to his death from a highway bridge to railroad tracks forty or fifty feet below. When last seen, the decedent was "standing on the

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Justice Mosk, joined by Justice Kennard, filed a dissent in Weil substantially longer than the court's lengthy opinion; the dissent urged abandonment of "accidental means." Both the dissent and the opinion of the court treated Cardozo's Landress dissent as a central ingredient of the jurisprudential debate. The focus of the Weil debate was whether death resulting from an overdose of cocaine was covered by a life insurance policy's "Additional Accidental Death Benefit" rider. The rider provided coverage for "loss of life as the direct result of bodily injury, independent of all other causes, effected solely through external, violent and accidental means."

outside of the bridge's guardrail, holding on to it with only his right hand." Id. at 1080. Whether Paul Wickman slipped or jumped could not be determined. After the claim filed by Mary Jane Wickman (the decedent's widow, and the beneficiary of his group accidental death and dismemberment policy) was denied by the insurance carrier, she brought a diversity action against the carrier in the United States District Court for Massachusetts. Because the group policy was one in which Paul Wickman had been enabled to participate as an incident of his employment, Mary Jane Wickman's state law contract claim on the policy was dismissed and the suit went forward not as a diversity case but as a federal question case arising under ERISA. After a bench trial, the magistrate judge handling the case dismissed the suit, concluding that Paul Wickman's death was not an accident within the meaning of policy terms defining an "accident" as "an unexpected, external, violent, and sudden event." In the view of the magistrate judge, "Mr. Wickman knew or should have known that serious bodily injury or death was a probable consequence substantially likely to occur as a result of placing himself outside of the guardrail and hanging on with one hand." Id. at 1081. On appeal, in addressing the question whether the magistrate judge had correctly determined that the decedent's death was not an accident within the meaning of the policy, the First Circuit observed that "we, of course, first look at the contract"; but the court found that the contract language definition of "accident" -"an unexpected, external, violent, and sudden event" - was "somewhat less than dispositive." Id. at 1084. The court explained: "It is undisputed that the fall was external, violent, and sudden,, but the parties disagree over whether it was unexpected .... The question comes down to what level of expectation is necessary for an act to constitute an accident; whether an intentional act proximately resulting in injury or only the ultimate injury itself must be accidental." Id. at 1085. Having framed the question in this way, the court explored the "accidental means"/"accidental result"

dichotomy and rejected "accidental means." "We elect to pursue a path for the federal common law which safely circumvents this Serbonian Bog." Id. at 1086. Nonetheless, the court went on to determine that the judgment of the magistrate judge was not erroneous: "[W]e conclude that this case is governed under ERISA, and that applying federal common law under ERISA, Paul Wickman's death did not constitute an accident within the terms of his group accident insurance policy. Wickman either subjectively expected serious injury, or the evidence was inconclusive as to his subjective expectation. Objectively, he reasonably should have expected serious injury when he climbed over the guardrail and suspended himself high above the railway tracks below by hanging on to the guardrail with only one hand." Id. at 1089. Thus, whether or not her claim was scrutinized through the prism of "accidental means," Mary Jane Wickman could not prevail.[4]

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In 1994 - four years after Wickman - the United States District Court for the Western District of Arkansas, citing Wickman, stated that "[t]he means-result distinction has been rejected in ERISA cases." Parker v. Danaher Corporation, 851 F. Supp. 1287, 1292 (W.D. Ark. 1994). Timothy Parker died of "autoerotic asphyxiation" - the unintended consequence of what is apparently a not uncommon "practice ... described as an act of autoerotic stimulation by means of a noose tightened around the neck for the purpose of temporarily restricting the supply of oxygen to the brain in an attempt to intensify the sensations of masturbation." Id. at 1289. Mary Faye Parker (the decedent's mother and his beneficiary under an employer-provided group life insurance policy) was paid $10,000 of standard life insurance benefits, but her claim for an additional $10,000 under the accidental death provisions of the policy - death pursuant to "bodily injury caused by an accident ... resulting directly and independently of all other causes in loss covered by this policy" - was rejected. On de novo review the district court found in plaintiff s favor. "We agree

with the Wickman court that the means-result distinction should not be adopted in ERISA cases. However, we find that the Wickman subjective/objective analysis sheds little light in an area of the law already unduly complicated by reference to various artificial distinctions. Rather, we believe it more appropriate to accord the term 'accident' its natural meaning .... In this case, it is undisputed that the insured did not expect to die as a result of performing the autoerotic act.... [W]e believe that in the common understanding of man Timothy Parker's death would be regarded as accidental." Id. at 1295. Thus, the Parker court, following its ERISA-based rejection of "accidental means," went on to conclude that the denial of Mary Faye Parker's accidental death benefits claim was erroneous. But - quite apart from the fact that the events leading to the death of Timothy Parker were entirely unlike the events leading to the death of Walter Buce - Parker sheds little light on the case at bar for the reason that Parker was an instance of de novo review of the denial of a benefits claim.

Unlike Parker, Wickman, as we have noted, was not a case in which the rejection of "accidental means" analysis had impact on the court's decision, for the First Circuit ruled that Paul Wickman's death was not an "accident" even under the broader concept of "accident" that the court deemed applicable. We think that the vital aspect of the First Circuit's approach in Wickman is reflected in the manner in which the Seventh Circuit built upon Wickman in Cozzie v. Metropolitan Life Insurance Company, 140 F.3d 1104 (7th Cir. 1998). Cozzie is an ERISA accidental death benefits case essentially indistinguishable on its facts from the case at bar:

> On November 6, 1994, Mr. Cozzie was killed in a car accident. According to investigators, Mr. Cozzie's vehicle was found overturned in a field, where it had come to rest, after missing a curve in the road, striking an embankment and rolling over three times. Mr. Cozzie had a blood alcohol level of .252%. This amount is more than 2+ times the legal limit under Illinois law at the time of the incident. The cause of death stated in the coroner's report was asphyxiation as

a result of the car's resting on Mr. Cozzie. There were no witnesses to the accident other than Mr. Cozzie's impaired condition.

Id. at 1106 (footnote omitted).

The district court, applying "arbitrary and capricious" review, granted summary judgment in favor of the insurance carrier. The Seventh Circuit affirmed. Drawing on Wickman. the Cozzie court said:

> Our colleagues in the First Circuit, in a thoughtful survey of the difficulties encountered by modem courts in developing a limiting principle to the term "accident," have suggested that, in giving meaning to the term "accident," we first ask whether the insured believed that the conduct at issue would result in the sort of injury that was sustained. See Wickman v. Northwestern Nat. Ins. Co., 908 F. 2d 1077, 1088 (1st Cir.), cert. denied, 498 U.S. 1013 (1990). If the insured did not believe that the result would occur, we must consider whether such an estimation can be considered reasonable. If the expectations were objectively unreasonable, then injuries from death resulting therefrom are not accidental. Id.
>
> Employing this approach to defining "accident," other courts have reached the conclusion that a death that occurs as a result of driving while intoxicated, although perhaps unintentional, is not an "accident" because that result is reasonably foreseeable. See Miller v. Auto-Alliance Int'l, Inc., 933 F. Supp. 172, 176 (E.D.Mich. 1997) (upholding MetLife's denial of AD & D benefits because definition of "accident" used - that death or injury resulting from driving while intoxicated reasonably should have been expected - was not arbitrary and capricious); Fowler v.Metropolitan Life Ins. Co., 938 F. Supp. 476,480 (W.D. Tenn. 1996)

In Wickman, as noted above, the term "accident", in an ERISA-governed group policy, was defined as an "unexpected, external, violent, and sudden event" a definition the First Circuit charitably described as "somewhat less than dispositive." In circumstances of this sort - where the crucial terms of an accident policy are defined with surpassing vagueness, and the policy contains no general guidance as to the construction of those terms - we think that to deploy the federal common law of ERISA to give some unity to the concept of "accident" is sound judicial policy. Concretely, we think that, in the case before it, the First Circuit was on eminently sound ground in ruling out "accidental means" and focusing instead on the objectively reasonable expectations of a person in the perilous situation that the decedent had placed himself in.

Wickman's rejection of "accidental means" does not, however, rule the case of Walter Buce. In the case at bar, the vague terms of the policy - "bodily injury caused by an accident ... and resulting directly and independently of all other causes in loss covered by the policy" - are given cognizable doctrinal context by another provision of the policy, the directive that "[t]he Plan is to be interpreted in accordance with the laws of the State of Georgia." Georgia - as this court held in Laney, supra - is an "accidental means" jurisdiction. Laney was

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(same); cf. McLain v. Metropolitan Life Ins. Co., 820 F. Supp. 169, 178 (D.N.J.. 1993) (upholding MetLife's denial of AD & D benefits and its definition of "accident" as not arbitrary and capricious in finding that death resulting from cocaine use was not accidental because insured reasonably should have expected death to occur).

Id. at 1109-10.

decided in 1985, the year that Walter Buce elected to become a participant in NSI's Personal Accident Insurance Plan. In Laney the decedent's widow brought suit, based on her husband's death from over- consumption of alcohol ("'acute ethanol intoxication (poisoning)'"), under a policy providing coverage for "loss ... resulting directly and independently of all other causes from bodily injuries caused by accident." In affirming the district court's grant of summary judgment in favor of the carrier, we addressed the meaning of "caused by accident" (the phrase which links Pat Laney and Walter Buce) under Georgia law. We reviewed "accidental means" case law in Georgia and neighboring jurisdictions. We noted that "[l]eading commentators on insurance law ... equate 'caused by accident' and 'accidental means.'" 757 F.2d at 1192. And we then said: "Finally, grammatical construction suggests that the two terms, 'caused by accident' and 'accidental means,' are synonymous and not the same as 'accidental injury.' In the phrase 'accidental means,' the word accidental is an adjective describing the quality of the events precipitating the ultimate result. The focus is on the occurrence or happening which produces the result, not the result itself. Similarly, in the phrase 'bodily injuries caused by accident,' the qualifier limits the cause of the harm to those circumstances where the result, i.e., the injury, is due to an unexpected, unforeseen or unintentional event." Id. In the case at bar, the July 11, 1997 letter of Allianz's attorney to Patricia Buce's attorney, John Robinson, giving the reasons for the carrier's denial of Mrs. Buce's claim, is in harmony with this court's explication in Laney of Georgia law. Wrote Allianz attorney Douglas Campbell: "This is an accident policy which, as applicable to this particular claim, provides payment of benefits where loss of life is due to bodily injury caused by an accident and resulting directly and independently of all other causes in death. As such, it is an 'accidental means' policy which requires that, in the act which preceded the injury, there must have occurred something

sudden, unexpected and unforeseen." Thus, in the light of the express directive of the policy that it "is to be interpreted in accordance with the laws of the State of Georgia," we conclude that Allianz's decision to deny the claim made by Patricia Buce survives "enhanced arbitrary and capricious" review."[5]

Citing three cases that have declined to enforce choice-of-law provisions in ERISA-regulated plans, Judge Carnes, in his concurring opinion, raises - but does not undertake to resolve - the question whether the common law of ERISA operates preemptively to preclude enforcement of the agreement of the parties to the insurance contract to utilize principles of Georgia law as the standards by which to determine the carrier's liability. There is, of course, no question that ERISA's preemptive authority sweeps broadly to preclude the application of provisions of state law (statutory or decisional) that would undercut the uniform implementation of ERISA's text or its attendant case law. See Egelhoff v.

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In the case at bar, the carrier's determination that Walter Buce's death was not an "accident" would clearly have satisfied the "arbitrary and capricious" review exercised by the Seventh Circuit in Cozzie v. Metropolitan Life Insurance Company, 140 F.3d 1104 (7th Cir. 1998), the factually almost congruent case discussed in footnote 4, supra for the reasons cogently articulated by the Cozzie court. Moreover, we think it strongly arguable that the Cozzie analysis, applied to the case at bar via the requisite "enhanced arbitrary and capricious" review, would likewise have led to the conclusion that the carrier's denial of benefits was warranted. However we need not resolve that issue, since, for the reasons given in the text of this opinion, we conclude that the carrier was warranted in denying Patricia Buce's claim on the basis of its "accidental means" analysis.

Egelhoff, 69 U.S.L.W. 4206 (March 21, 2001). The rationale of ERISA's preemption of otherwise applicable state law mandates is the rationale that underlies all federal preemption - namely, that in enforcing federal law the directives of the supreme federal sovereign take precedence over directives of the not-supreme state sovereign. But when private contracting parties formulate a choice-of-law provision that, with a view to defining liability, incorporates state legal doctrines, those doctrines are not emanations of state authority, they are simply a convenient shorthand for what the private contracting parties wish to agree to. The pertinent question to be addressed with respect to such a choice-of-law provision is, therefore, not a question of the possible irreconcilability of directives issuing from two different sovereignties one federal and one state. The pertinent question, in short, is not one of "preemption" in the conventional sense of that term. The pertinent question is whether the principles of liability agreed upon by the parties are inconsistent with the language of ERISA or the policies that inform that statute and animate the common. law of the statute.

In the case at bar, we have been pointed to no ERISA statutory language, and no cases formulating the common law of ERISA, which suggest that the agreement of the parties to utilize Georgia doctrine would be subversive of ERISA policy.[6]

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The cases cited in Judge Carnes's concurring opinion - Prudential Insurance Company of America v. Doe, 140 F.3d 785 (8th Cir. 1998); Morton v. Smith, 91 F.3d 867 (7th Cir. 1996); and In re Sears Retiree Group Life Insurance Litigation, 90 F.Supp. 2d 940 (N.D. Ill. 2000) - contain language dismissive of choice-of-law provisions found to contravene aspects of the common law of ERISA.

In Prudential Insurance the Eighth Circuit held that a choice-of-law provision invoking Illinois law, and hence the Illinois doctrine of contra proferentem, could not obviate application of a previously established circuit ruling that a Missouri contra proferentem "rule of construction violates the provisions of ERISA," Brewer v. Lincoln National Life Insurance Co., 921 F.2d 150, 153 (1990).

In Morton v. Smith the Seventh Circuit, in dictum, rejected an argument that ERISA trustees would be bound by a choice-of-law provision to exercise their discretionary authority in conformity with Illinois law, had such a provision been contained in the plan, which the court found it had not; but the court also went on to "note that the rule of contract interpretation [i.e., reference to state law] that Morton invokes here can sometimes be relevant to the interpretation of an ERISA benefit plan". 91 F.3d at 871 n. 1. The court then pointed to its prior ruling in Phillips v. National Life Insurance Co., 978 F.2d 302, 311-313 (7th Cir. 1992), that application of the Illinois contra proferentem rule in the interpretation of an ERISA-regulated plan was compatible with the common law of ERISA - a construction of the common law of ERISA which, as the Eighth Circuit noted in Prudential Insurance, is in conflict with the Eighth Circuit rule announced in Brewer and reaffirmed in Prudential Insurance.

Sears Retiree was a class action alleging breach of an ERISA-regulated life insurance plan through reductions of benefits for retired employees. The defendants invoked reservation of rights clauses in the policy as justifying the benefit-reductions, and the court noted that, "[i]n case after case, in this circuit and others, courts have held that employee benefit plans containing reservation of rights clauses do not give

From Cardozo onward, "accidental means" has been the subject of formidable criticism. But many jurisdictions - Georgia among them - continue to adhere to the doctrine. Given that the Personal Accident Insurance Plan at issue in this case was designed for the employees of a Georgia company, it is difficult to see that the parties' decision to utilize Georgia doctrine was inappropriate. "Where a choice of law is made by an ERISA contract, it should be followed, if not unreasonable or

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rise to vested welfare benefits." 90 F.Supp. 2d at 944-45. The plaintiffs countered that Illinois law barred reductions in retiree life insurance benefits, and contended that Illinois law, was controlling by virtue of a policy provision describing the policy as "an Illinois contract" which "will be construed in accordance with the laws of that jurisdiction." 90 F.Supp.2d at 950. The court, citing Tormey v. General American Life Ins. Co., 973 F.Supp. 805 (N.D. Ill. 1997), and Morton v. Smith, rejected plaintiffs' contention.

Each of the foregoing cases illustrates a circumstance in which a court found that application of a particular state law rule, even if agreed to by the parties, would not be compatible with the law of ERISA. But none of these discrete ERISA cases - and no other case of which we are aware - tends to establish the proposition that application of Georgia's "accidental means" doctrine to the Georgia-based ERISA benefits dispute at bar would undercut established principles of ERISA law. As noted above, in Morton v. Smith the Seventh Circuit pointed out that the contracting parties' reliance on state law doctrines "can sometimes be relevant to the interpretation of an ERISA benefit plan." No showing has been made that the case at bar is not such an instance.

fundamentally unfair." Wang Laboratories, Inc. v. Kagan, 990 F.2d 1126, 1128-29 (9th Cir. 1993).

The doctrine of "accidental means" may no longer be fashionable, but its use in this Georgia benefits plan can hardly be characterized as "unreasonable", let alone "fundamentally unfair". Accordingly, the District Court was without authority to determine that it should be disregarded. "The parties to accident insurance contracts have the right and power to contract as to the accidents and risks for which the company shall and shall not be liable, subject to the restraints of public policy, and the courts may not make new or different contracts for them." 10 Couch on Insurance 3d §139:8 (1998 ed.) (footnotes omitted).

Conclusion[7]

For the reasons given above, the judgment of the District Court is REVERSED and the cause REMANDED with directions to enter judgment dismissing the suit of plaintiff-appellee Patricia Buce against defendant-appellant Allianz.

REVERSED and REMANDED.

CARNES, Circuit Judge, concurring in the result:

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In view of our determination that Allianz's denial of benefits based on Georgia's "accidental means" doctrine was warranted, we have no occasion to consider whether, on the facts of this case, Allianz's denial of benefits was, in the alternative, properly based on the policy's intoxication exclusion provision.

I concur in the reversal of the district court's judgment because I reach the same bottom line conclusion as the majority about Allianz's decision to deny Patricia Buce's claim for death benefits - the denial was not arbitrary and capricious under the heightened standard of review. But I arrive at that conclusion by a different route than the majority. The route the majority follows involves a holding that ERISA does not preempt state law definitions of plan terms when those definitions are incorporated into the plan by a choice-of-law provision. That holding on an important issue of first impression in this circuit may be correct. Or it may not be.

Some other courts appear to have decided the issue differently. Those other courts have held that ERISA's preemption provision, among the broadest ever drafted by Congress, does preempt state law specified in plan choice of law provisions. See Prudential Ins. Co. of Am. v. Doe, 140 F.3d 785, 790-91 (8th Cir. 1998) (holding, in light of the "broad preemptive scope of ERISA," that "[t]he choice of law provision in the [benefits plan] does not alter the outcome here, for parties may not contract to choose state law as the governing law of an ERISA-governed benefit plan"); Morton v. Smith, 91 F.3d 867, 871 (7th Cir. 1996) (dictum) (choice-of-law provision does not control because the "federal common law of ERISA preempts most state law in regulating the interpretation of benefit plans"); In re Sears Retiree Group Life Ins. Litig., 90 F. Supp. 2d 940, 950-51 (N.D. Ill. 2000) ("A choice of law provision does not operate to waive the applicability of federal law regarding interpretation of an ERISA plan."). All of the cited decisions agree that choice of law provisions have no effect where, as here, the attempt is to choose state law as the source of interpretation for the terms of an ERISA plan.

I find it unnecessary to decide the ERISA preemption issue the majority addresses, or any other issue relating to how the Plan term "caused by an accident" is defined, because in my view Mrs. Buce's claim is precluded by the Plan's intoxication exclusion. That exclusion provides that "[Allianz] shall not be liable for any loss sustained in consequence of the person whose injury is the basis of claim being intoxicated."

Mr. Buce was exceedingly intoxicated when he died - a posthumously drawn blood sample measured his blood alcohol content at .22 percent, more than twice the legal limit. See O.C.G.A. § 40-6-391(a)(5) (.10 legal limit). The circumstances of Mr. Buce's death are that while driving drunk on an Interstate highway at 2:00 a.m., he lost control of his automobile and struck a guard rail. There was no evidence of a mechanical problem, no visible hazards, and no skid marks. The weather was clear and the highway was straight. His death was tragic, but the circumstances of it are all too typical of the thousands of alcohol-related traffic deaths that occur on our highways each year. See Michigan Dep't of State Police v. Sitz, 496 U.S. 444, 451, 110 S.Ct. 2481, 2485-86 (1990) ("Drunk drivers cause an annual death toll of over 25,000 and in the same time span cause nearly one million personal injuries and more than five billion dollars in property damage.") (footnote omitted) (quoting 4 W. LaFave, Search and Seizure: A Treatise on the Fourth Amendment § 10.8(d), p.71 (2d ed. 1987)). Mr. Buce's death represents a statistically predictable loss that the Plan in this case, like many other insurance policies, explicitly excludes. That exclusion is an independent, nonarbitrary basis that Allianz relied upon in denying death benefits.

The district court concluded that denying benefits on the basis of the intoxication exclusion was arbitrary and capricious for one reason: the 1985 summary plan description, the only one the Buces ever received, did not mention the Plan's intoxication

exclusion. Buce v. National Serv. Inds., Inc., 74 F. Supp.2d 1272, 1279-80 (N.D. Ga. 1999). The district court reasoned that where a plan and a summary plan description are inconsistent, the terms of the summary description control. Id. at 1279. Here, the district court determined that the two were inconsistent because the Plan contained an intoxication exclusion which the summary plan description did not mention. Id. Accordingly, the court concluded that Allianz's denial of death benefits on the basis of that exclusion was arbitrary and capricious under our heightened standard of review. Id. at 1280.

ERISA contemplates that the summary plan description will be the employee's primary source of information regarding benefits, and employees are entitled to rely on the description contained in it. See 29 U.S.C. § 1022(a) ("The summary plan description ... shall be sufficiently accurate and comprehensive to reasonably apprise ... participants and beneficiaries of their rights and obligations under the plan."); 29 C.F.R. § 2520.102-2(a). We have held that when a plan and its summary description conflict, and the employee or beneficiary demonstrates the requisite reliance, the terms of that description determine her eligibility for benefits. McKnight v. Southern Life & Health Ins. Co., 758 F.2d 1566, 1570 (11th Cir. 1985). As we explained in McKnight, "It is of no effect to publish and distribute a plan summary booklet designed to simplify and explain a voluminous and complex document, and then proclaim that any inconsistencies will be governed by the plan. Unfairness will flow to the employee for reasonably relying on the summary booklet." 758 F.2d at 1570. The district court credited Mrs. Buce's testimony that if the summary plan description had not omitted mention of the intoxication exclusion, she would have requested that an immediate autopsy be performed on her husband. That testimony, the district court concluded, satisfied the requirement of reliance. Buce, 74 F. Supp.2d at 1279.

I disagree. Mrs. Buce's testimony showed reliance, but it did not show detrimental reliance. In my view, Mrs. Buce was required to go beyond a simple showing that she acted or failed to act in some respect because of the Summary Plan Description's omission of the intoxication exclusion. Reliance connotes detriment. While we have never squarely held that an employee or beneficiary must show that her reliance on a statement or omission in the summary plan description was detrimental, we have indicated that she must. In Branch v. G. Bernd Co., 955 F.2d 1574 (11 th Cir. 1992), the terms of the plan specified an election period for obtaining continued coverage that differed from the election period given in the summary plan description. We held that the plan's terms, and not those of the summary plan description, governed the plaintiff s eligibility for benefits, because the plaintiff had provided "no evidence ... [that he had] ever read or relied on the summary." Id. at 1579-80. To be sure, the holding of Branch is simply that a plan trumps a summary plan description where there is no reliance at all, and there was no occasion to decide in that case whether the reliance required is detrimental reliance. See also Collins v. American Cast Iron Pipe Co., 105 F.3d 1368, 1371 (11th Cir. 1997) (plaintiff did not rely on faulty summary plan description because he did not read it until after he had filed his lawsuit).

But our discussion in Branch did provide an example of the kind of evidence that would satisfy the reliance requirement, and that example suggests that a showing that the reliance was detrimental is necessary in order to prevail on the basis of an omission in the summary plan description. We said:

> "a beneficiary who receives a summary that omits the plan's limit on the election period could prove reliance with evidence that the beneficiary received and read

the summary and failed to make a timely election based on the belief that there was no time limit."

Branch, 955 F.2d at 1579 n.2. I believe the negative implication of that dicta is correct. An employee or beneficiary is not harmed by non-detrimental reliance, and we ought not disregard a plan's otherwise controlling terms because of an omission from a summary plan description in the absence of harm. See Maxa v. John Alden Life Ins. Co., 972 F.2d 980, 984 (8th Cir. 1992) ("[I]n order to recover for a faulty plan summary, appellant must ... show that [he] took action, resulting in some detriment, that [he] would not have taken had [he] known [that the terms of the plan were otherwise].") (internal quotes and citation omitted).[1]

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Other courts have suggested the same proposition in dicta. See Health Cost Controls of Ill., Inc. v. Washington, 187 F.3d 703, 711 (7th Cir. 1999) ("When ... the plan and the summary plan description conflict, the former governs ... unless the plan participant or beneficiary has reasonably relied on the summary plan description to his detriment."); Stamper v. Total Petroleum, Inc., 188 F.3d 1233, 1243 (10th Cir. 1999) ("[A]ppellants make no claim that they actually detrimentally relied on the PD."). But see Aiken v. Policy Mgmt. Sys. Corp., 13 F.3d 138, 141 (4th Cir. 1993) (stressing that ERISA claimant must show either "significant reliance" or "possible prejudice"); Edwards v. State Farm Mut. Auto. Ins. Co., 851 F.2d 134, 137 (6th Cir. 1988) (claimant need not show detrimental reliance). Many of the courts that have considered this issue, however, have imposed the somewhat cryptic requirement that the employee or beneficiary show "some significant reliance upon, or possible prejudice flowing from, the faulty plan description." Govoni v. Bricklayers, Masons and Plasterers Int'l Union of Am., Local No. 5, 732 F.2d 250, 252 (Ist Cir. 1984); see, e.g., Gridley v. Cleveland Pneumatic Co., 924 F.2d 1310, 1319 n.8 (3d Cir. 1991).

Mrs. Buce has not made the required showing of detrimental reliance. Detrimental reliance or actual harm from a summary plan description's inconsistency with the plan can shown by evidence that because of that inconsistency the employee or beneficiary took or failed to take some action that prejudiced her claim for benefits under the ERISA plan. I accept the district court's credibility determination, and take as given that Mrs. Buce would have ordered an autopsy soon after her husband's death had the summary plan description informed her of the Plan's intoxication exclusion. I also accept her representation in this Court (although it stretches her testimony in the district court) that if she had known of the intoxication exclusion, she would have sought an investigation of the accident, an accident reconstruction, an examination of the vehicle, or all of those things. However, Mrs. Buce has provided no evidence that her failure to take any or all of those actions prejudiced her in regard to her claim for death benefits. We know Mr. Buce was extremely intoxicated when he died. We know the circumstances of the wreck. We also know that there is no evidence indicating that an autopsy, an accident reconstruction, or any additional investigation of the wreck would have pointed to anything other than the obvious, which is that serious injury or death are the all too predictable results of driving in a highly inebriated state. So, Mrs. Buce presented no evidence that her reliance on the summary plan description's omission of the intoxication exclusion worked to the actual detriment of her claim.[2]

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Mrs. Buce was given an opportunity in the district court to identify any detriment that she suffered from failing to take any steps she might have taken had she known of the intoxication exclusion. For example, the following exchange took place at trial:

Detrimental reliance or actual harm from a summary plan. description's inconsistency with the plan can also be shown by evidence that, but for the inconsistency, the employee or beneficiary would have obtained other insurance which would have paid benefits. But there is absolutely no evidence that if the summary description had referred to the intoxication exclusion either Mr. or Mrs. Buce would have purchased some other insurance policy that did not have such an exclusion.

I join the majority's reversal of the district court's judgment which set aside Allianz's denial of Mrs. Buce's death benefits claim. I would, however, base that reversal on the Plan's intoxication exclusion, and not on an interpretation of the Plan's terms drawn from Georgia law applied through the choice-of-law provision.

BARKETT, Circuit Judge, concurring, in which POLLAK, District Judge, joins:

I concur in the majority opinion and write only to expand on the question of whether an ERISA plan provider and its insured may agree that the plan's terms are to be construed in accordance with state law.

I start with the principle that the parties to a contract have the right to define the terms of that contract. Thus, in the insurance context, parties are free to agree upon the extent of coverage, to agree to lirmit insurance liability through

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Q: So you're not contending now that there is any specific thing or things that you think an autopsy would or might have revealed that might bear one way or another on this particular case; is that what you're saying?

R: I don't know what an autopsy would reveal.

exclusions or other contingencies and to agree to the manner in which the disputed meaning of contractual terms should be decided.[1] The question before this Court is whether ERISA precludes the parties to an agreement from using state law to define an ERISA contract's terms. In the absence of any compelling rationale to the contrary, I am not persuaded that ERISA sweeps so broadly.

To determine the extent of Congress' preemptive intent, courts first look to the language of the statute's preemption clause. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 95-100 (1983). In this case, ERISA's preemption clause, 29 U.S.C. §1144(a), contains no language that specifically prohibits the

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I recognize that an ERISA insurer's freedom to contract may be partially constrained by mandatory state laws for, when Congress passed ERISA, it recognized that states may create laws designed specifically to regulate the insurance industry, and an ERISA insurer is required to adhere to these laws as long as they fall within ERISA's "savings clause." See UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 363 (1999) (discussing 29 U.S.C. § 1144(b)(2)(A)). To fall under the protection of the "savings clause" the state law must: (1) from "a common-sense view of the matter ... regulate[] insurance"; (2) "ha[ve] the effect of transferring or spreading a policyholder's risk"; (3) concern a practice "integral ... [to] the policy relationship between the insurer and the insured;" and (4) concern a "practice ... limited to entities within the insurance industry." Id. at 367. However, the limits the "savings clause" imposes on an ERISA insurer's freedom to contract have no bearing on whether an ERISA insurer may voluntarily choose to adopt other state law standards to govern the interpretation of an ERISA policy's terms.

application of the choice of law agreement in this case.[2] The preemption language of ERISA, although broad, does not address the question of whether a choice of law agreement may be enforced. It simply provides that:

> [e]xcept as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a). To answer the question presented here, we must discern the meaning of the terms "relates to" and "State laws."

The Supreme Court has recognized that ERISA's preemption clause is "not a model of legislative drafting," Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 7245 740 (1985); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 415 46 (1987), and has provided guidance to resolve the question before us. In De Buono v. NYSA- Medical and Clinical Services Fund, the Court explained:

> in our earlier cases, we noted that the literal text of [ERISA's preemption clause] [wa]s 'clearly expansive.' (citing by example New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins.

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Indeed, there is nothing in ERISA generally that addresses how contractual terms such as "accident" should be defined or interpreted.

> Co., 514 U.S. 645, 655 (1995) ("Travelers")). But we were quite clear . . . that the text could not be read to 'extend to the furthest stretch of its indeterminacy, [or] for all practical purposes preemption would never run its course,' for '[r]eally, universally, relations stop nowhere.'

520 U.S. 806, 813 (1997) (citing H. James, Roderick Hudson x1i (New York ed., World's Classics 1980)). See also California Div. of Labor Standards Enforcement v. Dillingham Const., N.A., Inc., 519 U.S. 316, 335 (1997) ("Dillingham") (explaining that application of the preemption clause "was a project doomed to failure, since, as many a curbstone philosopher has observed, everything is related to everything else.")

In De Buono, the Supreme Court noted that in the early ERISA preemption clause cases, the state laws at issue had a clear "connection with or reference to ERISA benefit plans." 520 U.S. at 813 (internal citations omitted). Thus, in those cases it was "not ... necessary to rely on the expansive character of ERISA's literal language in order to find preemption." Id. Ultimately, when confronted with the question of whether Congress intended ERISA's "relates to" language to modify "the starting presumption that Congress does not intend to supplant state law," the Supreme Court explained that it "unequivocally concluded that it did not. . ." Id.

In De Buono, the Supreme Court also acknowledged that its "prior attempt[s] to construe the phrase 'relate[s] to' d[id] not give ... much help [in] drawing the line" between the issues preempted by §1144(a) and those unaffected by the provision. De Buono, 520 U.S. at 813 (citing Travelers, 514 U.S. at 655). However, the Supreme Court explained that:

> [i]n order to evaluate whether the normal presumption against preemption has been overcome in a particular case, we [have] concluded that we 'must go beyond the unhelpful text [in §1144(a)] and the frustrating difficulty of defining its key term[s], and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.'

De Buono, 520 U.S. at 813-14 (citing Travelers, 514 U.S. at 656). The Supreme Court reiterated this view in Dillingham, noting that the statute at issue there, a wage law, was no different from myriad state laws in areas traditionally subject to local regulation, and when Congress enacted the ERISA preemption clause, it could not possibly have intended to eliminate all of these laws.[3] Dillingham, 519 U.S. at 334.

In my view, nothing in ERISA suggests that Congress intended to preempt the agreement of the parties here. Rather, when Congress enacted ERISA, it was concerned about the enormous number of benefit plans which were receiving preferential tax treatment, but were not protecting long term employees from losing anticipated retirement benefits because the plans lacked vesting provisions. See 29 U.S.C. §1001 (a).

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Specifically, the Dillingham Court explained, "we could not hold pre-empted a state law in an area of traditional state regulation based on so tenuous a relation without doing grave violence to our presumption that Congress intended nothing of the sort. We thus conclude that California's prevailing wage laws and apprenticeship standards do not have a 'connection with,' and therefore do not 'relate to,' ERISA plans." Dillingham, 519 U.S. at 334.

It was also concerned about how many employee benefit plans contained inadequate minimum protective standards and, as a result, were unable to pay promised benefits or were forced to terminate the plans before the requisite funds had been accumulated. Id. Congress, therefore, created a statute which would standardize "disclosure and reporting [obligations] to participants and beneficiaries ... [with regard to] financial and other information"; establish "standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans"; create vesting standards for employees with significant periods of service"; erect minimum funding standards for plans and require plan termination insurance; and "provid[e] for appropriate remedies, sanctions, and ready access to the federal courts." 29 U.S.C. § 1001(b) & (c).

When one looks at ERISA's preemption clause in light of Congress' goals for the entire statute, it seems clear that Congress was simply ensuring that no state regulation would supersede the protections provided by the statute's provisions. Therefore, consistent with these goals, the phrase "State laws" in §1144(a) refers to the conflicting legislative acts of a state (and any court interpretation of those legislative acts). There is nothing in the goals and purposes of ERISA that extends to non-conflicting agreements to be bound by the decisional law of state courts in interpreting ambiguous terms in their contracts.

Indeed, no Supreme Court case has addressed ERISA preemption in light of private agreements concerning state law. Rather, all of the Supreme Court's ERISA preemption cases address the question of whether state legislative enactments affect the regulation, operation, structure and policy concerns of ERISA, or whether state law causes of action conflict with the statute's enforcement mechanisms. See Eglehoff v. Eglehoff -- S.Ct. --, 2001 WL 273198 (March 21, 2001) (holding that a Washington state law which automatically revoked designation

of spouse as plan beneficiary upon divorce was preempted as applied to ERISA plans because it conflicted with ERISA's requirement that a plan be administered according to the plan's terms); UNUM, 526 U.S. 358 (1999) (holding, inter alia, that California agency law establishing that a employer was an agent of the insurer providing its insurance policies was preempted by ERISA); Boggs v. Boggs, 520 U.S. 833 (1997) (holding that ERISA preempted a Louisiana state law regulating community property when the insured sought to use a testamentary transfer to convey his interest in an ERISA plan); De Buono, 520 U.S. 806 (1997) (holding that ERISA did not preempt a New York state tax on the gross receipts of health care facilities operated by an ERISA fund); Travelers, 514 U.S. 645 (1995) (holding that ERISA did not preempt a New York statute requiring hospitals to collect surcharges from patients covered by a commercial insurer but not from a patient insured by a Blue Cross Blue Shield plan); John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank, 510 U.S. 86 (1993) (recognizing that ERISA's fiduciary duties provisions do not always preempt state law obligations for fiduciaries managing benefit plans); Dist. of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125 (1992) (holding that the District of Columbia Worker's Compensation Equity Amendment Act explicitly referred to ERISA and was therefore preempted); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) (holding that a Texas state law claim for wrongful discharge was preempted when it was based on the allegation that the termination was motivated by the employer's desire to avoid payment of ERISA benefits); FMC Corp. v. Holliday, 498 U.S. 52 (1990)(holding that ERISA preempted application of the Pennsylvania Motor Vehicle Financial Responsibility Law to an ERISA governed health care plan); Massachusetts v. Morash, 490 U.S. 107 (1989) (holding that Massachusetts criminal statute requiring employers to pay employees for unused vacation time was not preempted by ERISA because it did not concern an ERISA

benefit plan); Mackey v. Lanier Collection Agency & Service, Inc., 486 U.S. 825 (1988) (holding that a Georgia state law specifically protecting ERISA benefits from garnishment was preempted by ERISA and that ERISA benefits could be garnished under generally applicable Georgia law); Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) (holding that Maine law requiring one time severance payment for employees of closed plants was not preempted by ERISA); Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58 (1987) (holding that plaintiff s Michigan tort and contract claims for wrongful denial of ERISA benefits were preempted by ERISA); Pilot Life, 481 U.S. 41 (1987) (holding that Mississippi state law claims for wrongful denial of ERISA plan benefits were preempted by ERISA); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) (holding that Massachusetts insurance law requiring certain benefits was not preempted by ERISA because it fell within ERISA's "savings clause"); Shaw, 463 U.S. 85 (1983) (holding that ERISA preempted New York Human Rights Law to the extent that it imposed conflicting insurance obligations than required under ERISA but that New York Disability Law was not preempted if not applied to ERISA plans); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981) (holding that New Jersey statute barring certain calculations for pension benefits was preempted under ERISA).

The only circuit court which has addressed a case similar to this one is the Eighth Circuit in Prudential Insurance Company of America v. Doe, 140 F.3d 785, 790-91 (8th Cir. 1998), which relied on the earlier case of Brewer v. Lincoln National Life Insurance Comp, 921 F.2d 150, 153-54 (8th Cir. 1990).[4] In Prudential, the Eighth Circuit declined to enforce a

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4 I do not find ERISA cases concerning disputes about

statutes of limitations analogous, because these cases are decided under the federal common law rule permitting the courts to select a statute of limitations from the law of the forum when a federal cause of action does not have one. See Wilson v. Garcia, 471 U.S. 261, 268 (1985) (explaining that when Congress fails to provide a statute of limitations for a federal cause of action it is Congress' intent for courts to apply the statute of limitation from the most analogous cause of action under state law). Three courts have relied on this rule as an explanation for why they would not select a statute of limitations for a party's ERISA claim based on the law indicated by the choice of law agreement in the parties' ERISA contract. See, e.g., Central States Southeast & Southwest Areas Pension Fund v. Kraftco, Inc., 799 F.2d 1098, 1104-05 (6th Cir. 1986) (explaining that "when Congress has not established a time limitation for a federal cause of action, the settled practice has been to adopt a local time limitation as federal law if it is not inconsistent with federal law or policy to do so."). See also Gluck v. Uniysis, 960 F.2d 1168, 1180 (3d Cir. 1992) (applying rule and explaining that "choice of law provisions in contracts do not apply to statutes of limitations, unless the reference is express."); Robbins v. Iowa Builders, Co., 828 F.2d 1348,1352 -53 (8th Cir. 1987) (following the same rule and commenting that choice of law provisions are irrelevant to an ERISA action because these provisions are only relevant to diversity cases). However, at least one court has concluded that the federal rule for selecting statutes of limitations can be suspended by the parties' choice of law agreement. See Wang v. Kagan, 990 F.2d 1126, 1129 (9th Cir. 1993) (applying choice of law agreement in ERISA benefit plan to decide statute of limitations question because the provision was "not unreasonable" or "fundamentally unfair"). Because the federal common law rule for identifying statutes of limitations is independent of our concerns regarding

choice of law agreement providing for Illinois law to govern. the interpretation of the term "mental illness" in the ERISA policy. The Prudential Court, without explanation, simply stated, "[a]lthough choice of law provisions may be relevant in a diversity action, we are required to apply federal common law when deciding federal questions. In light of the broad preemptive scope of ERISA, the question of coverage ... is clearly one of federal law." Id. at 791. In the earlier Brewer case, the Eighth Circuit declined to apply a choice of law agreement in the same context stating, again without analysis, that ERISA's "preemption clause applies broadly to all state laws that have any direct or indirect relation to pension plans, even if they were not specifically designed for that purpose," and are only saved from preemption if they fall within ERISA's "savings clause." 921 F.2d at 153-54.

Neither Prudential nor Brewer offer any compelling rationale for why ERISA's preemption clause should be construed to wholly bar the general practice of agreements between insurers and insureds as to how their insurance policy's terms will be construed. Thus, I concur with Judge Pollak's assessment that ERISA's preemption clause does not bar the enforcement of a choice of law agreement, as long as the law applied does not conflict with ERISA's statutory language or policy goals.

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whether one can elect to contract around the substantive definitions for policy terms under the federal common law of ERISA, I do not rely on these cases for my analysis.

APPENDIX "B"

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 99-1540S BB
FILED
U.S. COURT OF APPEALS
ELEVENTH CIRCUIT
JULY 21, 2001 [sic: actually filed June 21, 2001]
THOMAS K KAHN
CLERK

PATRICIA W. BUCE,
Plaintiff-Appellee,

versus

ALLIANZ LIFE INSURANCE COMPANY f.k.a. North American Life and Casualty Company,
Defendant-Appellant,

On Appeal from the United States District Court for the Northern District of Georgia

ON PETITION(S) FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC

(Opinion _____, 11th Cir., 19__, _____ F. 2d _____).

Before: CARNES and BARKETT, Circuit Judges, and POLLAK*, District Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

s/_____
UNITED STATES CIRCUIT JUDGE

*Honorable Louis H. Pollak, U.S. District Court for the Eastern District of Pennsylvania, sitting by designation.

APPENDIX "C"

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

CIVIL ACTION FILE NO. 1:98-CV-112-TWT

PATRICIA W. BUCE,
Plaintiff,

v.

NATIONAL SERVICE INDUSTRIES, INC., et al.,
Defendants.

ENTERED IN CHAMBERS
THOMAS W. THRASH, JR.
U.S.D.C. ATLANTA
NOV. 16, 1999
LUTHER D. THOMAS,
CLERK

ORDER

This action is brought pursuant to the Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. ("ERISA"). At issue is the denial of death benefits under an accidental death policy. The Court previously granted in part and denied in part the motions for summary judgment of the Defendants. On November 8 and 9, 1999, the Court conducted a bench trial regarding Plaintiff s claim for death benefits. The Court's findings of fact and conclusions of law are set forth below.

FINDINGS OF FACT

1. Mr. Walter H. Buce, Jr. was a long time employee of NSI. He was enrolled in NSI's optional Personal Accident Insurance Plan. Plaintiff Patricia Buce brings this action as the surviving beneficiary for the death benefits provided by the Plan.

2. Mr. Buce died in a car crash while driving on Interstate 75 near Cleveland, Tennessee on December 13, 1995. Around 2:00 A.M., his car struck a guard rail, rolled over, and burst into flames. According to the Tennessee Bureau of Investigation, Mr. Buce had a blood alcohol content of .22%. There were no witnesses to the accident and no other vehicles involved. The coroner's death certificate attributed Mr. Buce's death to multiple third degree bums as a consequence of a motor vehicle wreck.

3. NSI offered the Personal Accident Insurance Plan as an optional fringe benefit of employment. Mr. Buce enrolled in the Plan on or about April 1, 1985. He designated his wife as the beneficiary and elected coverage in the amount of $150,000. All premiums were paid and the policy was in force and effect at the time of Mr. Buce's death.

4. On or about April 1, 1985, Mr. Buce was given a Summary Plan Description as required by ERISA. The Summary Plan Description and a Certificate of Insurance were included in a booklet entitled Personal Accident Insurance Plan. Based upon the responses of NSI to Plaintiffs interrogatories, the Court finds as a matter of fact that the 1985 Summary Plan Description was the only one ever issued to either Mr. or Mrs. Buce.

5. The Summary Plan Description contains a section entitled "EXCLUSIONS." It lists the following four exclusions for injury or loss due to: (1) riding in an aircraft other than as a passenger for transportation; (2) suicide; (3) war; and (4) service in the armed forces.

6. The Summary Plan Description states: "The insurance company has the exclusive right to interpret the provisions of the Plan, so its decision is conclusive and binding."

7. The Plan was initially underwritten by Firemen's Fund. When NSI changed carriers[1], it issued a new plan booklet and added language to the Summary Plan Description. For example, the new Summary Plan Description added an exclusion for injuries or death caused by or resulting from intoxication. At the time of his death, Mr. Buce was not in possession of the revised Summary Plan Description, and the Defendants have offered no evidence that he ever actually received the revised Summary Plan Description.

8. After her husband's death, Plaintiff submitted a claim for benefits under the plan to NSI. NSI sent the claim to their underwriter, Defendant Allianz Life Insurance Company. Allianz submitted the claim to its third-party administrator, American Special Risk Management (hereafter "ASRM"). At the time, ASRM's sole client was Allianz. ASRM denied the claim based upon an intoxication exclusion. [Joint Ex. 16].

9. The intoxication exclusion is not mentioned in the Summary Plan Description sent to the Buces, but appears in the Certificate of Insurance issued by Fireman's Fund with the Summary Plan Description.

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1 Around 1993, Allianz Life Insurance Co. (f/k/a North American Life and Casualty Co.) became the underwriter for the Plan.

The Certificate of Insurance states: "The Company shall not be liable for any loss sustained in consequence of the person whose injury is the basis of the claim being intoxicated or under the influence of any narcotic unless administered on the advice of a physician." [Plaintiffs Ex. 2, pg. 13].

10. The Certificate of Insurance also defines "injury" to mean "bodily injury caused by an accident ... and resulting directly and independently of all other causes..." [Id. at 11

11. Plaintiff appealed the denial of benefits and submitted affidavits on her behalf to ASRM. The Affidavits are Joint Exhibits 5, 6, 7, 8 and 9.

12. Considering this evidence, Allianz rejected Plaintiffs claim. Allianz, through its attorney, took the position that the policy was an "accidental means" policy which requires that the act preceding the loss must be "sudden, unexpected and unforeseen." Alternatively, and in response to the doctor's affidavit, Allianz took the position that even if Mr. Buce died of a heart attack, this did not constitute an "accident" as defined by the policy. Under the policy, death from a heart attack would be from natural causes. [Joint Ex. 18].

14. [sic] After exhausting her administrative remedies, Plaintiff filed this lawsuit pursuant to 29 U.S.C. §§ 1024(b)(1), 1022(a)(1), and 1022(b).

CONCLUSIONS OF LAW

A. ERISA STANDARD OF REVIEW.

Plaintiff's Complaint alleges violations of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, 1140. In adopting ERISA, Congress sought to protect participants in employee benefit plans and their beneficiaries by requiring disclosure and reporting of financial and other information; establishing standards of conduct for fiduciaries of those plans; and providing for appropriate remedies, sanctions, and ready access to the federal courts. 29 U.S.C. § 1001(b). At the outset in an action such as this, the Court must determine the standard by which to review the Defendants' decision to deny the death benefits claimed by Plaintiff. The Act itself does not provide a standard of review for decisions of a plan administrator or fiduciary. In the absence of statutory guidance, the Supreme Court has established a range of standards for judicial review of benefits determinations under ERISA. In Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), the Supreme Court held:

> "[A] denial of benefits challenged under §1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan .... Of course, if a benefit plan gives discretion to an administrator or fiduciary operating under a conflict of interest, that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion."

Id. at 115 (citations and quotation marks omitted).

Consistent with Firestone, the Eleventh Circuit has adopted three standards for judicial review of an administrator's benefits determination: (1) *de novo* review where the plan administrator is not afforded discretion; (2) arbitrary and capricious standard when the plan grants discretion to the plan administrator; and (3) heightened arbitrary and capricious standard where there is a conflict of interest. Brown v. Blue Cross and Blue Shield of America, Inc., 898 F.2d 1556,1561 (11th Cir. 1990), cert. denied, 498 U.S. 1040 (1991); Paramore v. Delta Air Lines, Inc., 129 F.3d 1446, 1449- (11th Cir. 1997); Buckley v. Metropolitan Life, 115 F.3d 936, 939 (11th Cir. 1997). Under the heightened arbitrary and capricious standard, the burden shifts to the plan administrator or fiduciary, acting under a conflict of interest, to show that its interpretation of plan terms committed to its discretion was not tainted by self-interest. Florence Nightingale Nursing Service, Inc. v. Blue Cross/Blue Shield of Alabama, 41 F.3d 1476, 1481 (11th Cir. 1995), cert. denied 514 U.S. 1128 (1995). The Eleventh Circuit has held that "the heightened arbitrary and capricious standard must be used when the plan was administered by an insurance company which paid benefits out of its own assets." Buckley, 115 F.3d at 939. The Eleventh Circuit in Brown reasoned that "[b]ecause an insurance company pays out to beneficiaries from its own assets rather than the assets of a trust, its fiduciary role lies in perpetual conflict with its profit-making role as a business." Brown, 898 F.2d at 1561.

Here, it is undisputed that the *de novo* standard does not apply because of the discretion afforded the insurer by the plan. The Summary Plan Description provides: "The insurance company has the exclusive right to interpret the provisions of the Plan, so its decision is conclusive and binding." The parties disagree as to which of the remaining two standards of review applies. Defendants argue that the proper standard is whether the benefits determination was arbitrary and capricious. See

Guy v. Southeastern Iron Worker's Welfare Fund, 877 F.2d 37, 38 (11th Cir. 1989); Jett v. Blue Cross & Blue Shield of Alabama, Inc., 890 F.2d 1137,1138 (11th Cir. 1989). They deny that the benefits determination was affected by self-interest. Plaintiff argues for the heightened scrutiny version of the arbitrary and capricious standard. See Lee v. Blue Cross/Blue Shield of Alabama, 10 F.3d 1547 (11th Cir. 1994).

The Court finds that there is a conflict of interest. A judgment in favor of Plaintiff will have to be paid by Allianz. This creates the "direct, immediate expense" that the Court of Appeals in Brown identified. Brown, 898 F.2d at 1561. There, Blue Cross determined whether it would pay benefits from its own coffers-an inherent and obvious conflict of interest. The situation here differs only slightly with ASRM evaluating Plaintiff s claim for its only client and then a final decision by Allianz. Therefore, the Court may review the determination of benefits under the heightened arbitrary and capricious standard. Application of the heightened standard from Brown requires two steps. First, the Court must determine whether under a *de novo* review Plaintiff has offered a sufficiently sound interpretation of the disputed plan provision to rival the Defendants' contrary determination. Cargile v. Confederation Life Ins. Group Plans, 748 F.Supp. 874, 878 (N.D. Ga. 1990). Second, the Court must determine whether the fiduciary's adoption of the different interpretation was "arbitrary and capricious." Id. at 878-79.

B. ACCIDENT OR ACCIDENTAL MEANS.

The first question to be addressed is whether the insurance company properly interpreted the Plan by reading into the policy an exclusion for injury or death that is foreseeable based upon such risk increasing behavior as driving while intoxicated. In Laney v. Continental Ins. Co., 757 F.2d 1190

(11th Cir. 1985), the Eleventh Circuit addressed this issue in the context of a diversity case applying Georgia law. The decedent in that case died of acute alcohol poisoning; the autopsy showed a blood alcohol content of .47 grams percent. The court recognized that Georgia law distinguishes between the terms "accidental injury" and "injuries resulting from accidental means." Id. at 1191. Applying Georgia law, the court concluded that "caused by accident" is synonymous with "accidental means." Id. at 1192. "The focus is on the occurrence or happening which produces the result, not the result itself." Id. The court then concluded:

> "Given this construction of the policy term, it is evident that the defendant was entitled to judgment as a matter of law. Mrs. Laney does not dispute that her husband intentionally and voluntarily drank the alcohol that caused his death. Nor does she contend that some mischance, slip or mishap occurred during his consumption of the whiskey and beer to cause him to consume more than he intended. Although the result of his drinking was unexpected, the act of drinking was intentional. Georgia law makes it clear that such conduct is not covered by an "accidental means" policy."

Id. See also Continental Assurance Company v. Rothell, 227 Ga. 258 (1971). A reasonable person would have foreseen that driving with a blood alcohol level of .22 grams percent was highly likely to result in injury or death. If Laney or Georgia law applies to this case, the Court should enter judgment in favor of the Defendants and against the Plaintiff. Nevertheless, it is also unquestionably true that the ordinary purchaser of an accidental death insurance policy would think that the unintentional and unexpected burning to death as a result of a car wreck constitutes death by accident.

The Eleventh Circuit has clearly held that ERISA preempts state law and authorizes federal courts to create federal common law to implement Congress' statutory scheme. Branch v. G. Bernd Co., 955 F.2d 1574, 1580 (11th Cir. 1992). In this case, the Court is faced with the question of whether to frustrate the statutory scheme of ERISA by adhering to the metaphysical distinction between "accidental means" and "accidental results" that has bedeviled the courts for more than 60 years. In Landress v. Phoenix Mut. Life Ins. Co., 291 U.S. 491 (1934), the insured died after suffering sunstroke. The majority said that since the insured voluntarily exposed himself to the sun and there were no unforeseen intervening causes, the death was not caused by accidental means. Justice Cardozo dissented:

> "The attempted distinction between accidental results and accidental means will plunge this branch of the law into a Serbonian Bog. Probably it is true to say that in the strictest sense and dealing with the region of physical nature there is no such thing as an accident.... On the other hand, the average man is convinced that there is, and so certainly is the man who takes out a policy of accident insurance. It is his reading of the policy that is to be accepted as our guide, with the help of the established rule that ambiguities and uncertainties are to be resolved against the company.... When a man has died in such a way that his death is spoken of as an accident, he has died because of an accident, and hence by accidental means...."

Id., 291 U.S. at 499. Unfortunately, Justice Cardozo's prophesy was fulfilled. Fortunately, however, the clear trend in recent years has been to climb out of the Serbonian Bog. Unquestionably, the Congressional purpose of protecting the

interests of ERISA beneficiaries would be promoted by following this trend.

The Supreme Court of Tennessee recently addressed this issue in the case of Harrell v. Minnesota Mutual Life Ins. Co., 937 S.W. 2d 809 (Tenn. 1996). It noted that the view of Justice Cardozo has now gained the support of the great majority of jurisdictions. The court cited one well respected authority in the field as follows:

> "Almost every action we take has some element of design; if we drive an automobile upon the highway, where another collided with us, could this not have been foreseeable, or at least within the realm of potential so far as the "means" were concerned? Every instance where a person walks, or jumps, and slips or falls, comes within a like category. To permit a rigid construction of such expressions is to permit a deception to be practiced upon the public...."

Id. at 813 (citing 1 A Appleman, Insurance Law & Practice, §363 at p. 492 (1981 & Supp. 1995)). The court then observed:

> "Although a few courts in other jurisdictions still cling to the distinction, most courts have either abolished the distinction or refused to recognize it in the first place when considering whether a particular death or injury is accidental. Under the more recent cases, the unexpected consequences of an individual's voluntary behavior provide the accidental element for purposes of an insurance policy."

Id. (footnotes omitted). The Tennessee court also recognized, as have other courts, that the distinction between accidental

means and accidental results distorts the law in "that it subjects contract terms to analysis under tort principles, such as fault and foreseeability." Id. at 814 (citing Fryman v. Pilot Life Ins. Co., 704 S.W.2d 205, 206 (Ky. 1986)). The court concluded:

> "Accordingly, [Mutual Life Ins. Co. of New York v. Distretti, 159 Tenn. 138, 17 S.W. 2d 11 (1929)], its progenitors and progeny are overruled.[2] From this day forward, in Tennessee law there is no distinction between "accidental death" and death by "accidental means" in determining coverage under an

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A couple of the cases relied upon by Allianz relied upon Distretti or its progeny to deny benefits in drunk driving cases. See Smith v. Life Ins. Co. of North America, 872 F.Supp. 482 (W.D. Tenn. 1994); Fowler v. Metropolitan Life Ins. Co., 938 F.Supp. 476 (W. D. Tenn. 1996). Others involved different policy provisions. See Cates v. Metropolitan Life Ins. Co., 1998 WL 385897 (6th Cir. 1998) (policy excluded coverage for injuries contributed to by drug/alcohol use); Wickman v. Northwestern National Insurance Company, 908 F.2d 1077 (11th Cir. 1990) (policy defined "accident" as "an unexpected, external, violent, and sudden event"); Walker v. Metropolitan Life Insurance Company, 24 F.Supp. 2d 775 (E.D. Mich. 1997) (policy excluded coverage for "injuring yourself on purpose"); Nelson v. Sun Life Assurance Co., 962 F.Supp. 1010 (W.D. Mich. 1997) (exclusion for self-inflicted injuries); Morton v. Smith, 91 F.3d 867 (7th Cir. 1996) (applying exclusion for self inflicted injuries). Id. at 814-815. See also Wickman v. Northwestern Nat. Ins. Co., 908 F.2d 1077, 1088 (1st Cir. 1990) ("Generally, insureds purchase accident insurance for the very purpose of obtaining protection from their own miscalculations and misjudgments").

> insurance policy. Instead, if death is the unanticipated and unexpected result of an intentional, voluntary act, it is accidental in the ordinary and plain sense of the word and recovery is available under an accidental death insurance policy. Accidental deaths or injuries which are included within this definition, but which the insurance company does not intend be covered, can be specifically excluded in the insurance policy."

At trial, counsel for Allianz clearly articulated the insurance company's interpretation of the policy. According to counsel, any conduct that increases the risk to the insurance company above and beyond the risk of "normal" behavior is a foreseeable cause of injury and is not covered by the policy. This is the logical end result of reading a foreseeability exclusion into the policy. Nevertheless, there are a number of problems with this interpretation of the policy, all of which are well recognized by the commentators and leading cases in this area. First, the policy itself says nothing about excluding foreseeable injuries. Allowing the insurance company to escape from providing the coverage which it promised in the policy is to sanction the deception of the public described by Appleman. Second, reading a foreseeability exclusion into the policy serves no public interest. See Miller v. American Cas. Co. of Reading, Penn., 377 F.2d 479, 480 (6th Cir. 1967) (no mandate in law or public policy to imply an intoxication exclusion when none was agreed on by the parties when the insurance contract was signed). The insurance company gets a windfall for collecting premiums (in this case for 10 years) based upon the appearance of providing coverage for what the average insured would consider an accident. Denying coverage after the fact does not provide an incentive to the insured to modify his behavior because the exclusion is undisclosed, and serves only to punish the beneficiaries, such as the widow in this case, that the insured thought he was protecting. If the insurance company does not

want to insure certain risks, such as driving while intoxicated, it should include an explicit exclusion to that effect in the policy. That will give the insured the incentive not to engage in the risky behavior. In fact, that is what the insurance company did by putting certain exclusions in the policy. For example, there is a suicide exclusion. It is foreseeable that a suicide attempt will result in serious injury or death. If the policy already excluded coverage for foreseeable injuries, there was no need for a suicide exclusion unless this was part of a trick to deceive the public into thinking that the policy really provided the sort of coverage the average insured would expect.

Finally, the insurance company's interpretation of the policy takes us into a sub-Serbonian Bog when we try to define what is "normal" behavior. Driving on the interstate highways in Atlanta increases the risk of a serious car wreck as compared to sticking to the surface streets. Is this not normal behavior? Driving in excess of the speed limit increases the risk of a serious car wreck. Is this not normal behavior? The undersigned enjoys standing in the middle of big rivers casting bits of hair and fur at fish. This certainly increases the risk of drowning as compared to staying at home and sitting on the couch. Is this not normal behavior? Is the judge's widow to be deprived of protection because of his piscatorial pursuits?

For all of these reasons, the Court is persuaded that the developing ERISA federal common law should not fall back into Justice Cardozo's Serbonian Bog. There is no controlling Eleventh Circuit authority to the contrary because Laney was a diversity case and did not involve ERISA federal common law. Schultz v. Metropolitan Life Ins. Co., 994 F.Supp. 1419, 1421 (M.D. Fla. 1997). The Eleventh Circuit has clearly stated the process for determining ERISA common law:

> "To decide whether a particular rule should become part of ERISA's common law, courts must examine whether the rule, if adopted, would further ERISA's scheme and goals. ERISA has two central goals: (1) protection of the interests of employees and their beneficiaries in employee benefit plans; and (2) uniformity in the administration of employee benefit plans."

Horton v. Reliance Standard Life Ins. Co., 141 F.3d 1038, 1041 (11th Cir. 1998) (citations omitted). Reading a foreseeability exclusion into the policy would frustrate the Congressional purpose of protecting ERISA plan beneficiaries. It would not contribute to uniformity in the administration of employee benefit plans. A foreseeability exclusion contributes to uncertainty and difficulty of administration. "[A]n insured should not have to consult a long line of case law or law review articles and treatises to determine the coverage he or she is purchasing under an insurance policy." Harrell, 937 S.W. 2d at 814.

For the reasons set forth above, the Court finds that Allianz applied an incorrect legal standard to the determination of whether Mr. Buce died as a result of an accident. Allianz had a conflict of interest in making this determination because its restrictive interpretation of the policy allowed it to deny the claim and save the money it would have paid if the claim had been allowed. This conflict of interest may be considered in applying the heightened arbitrary and capricious standard of review. Plaintiffs deceased husband purchased an insurance policy to protect his family in case of accidental death. He paid the premiums on the policy for more than 10 years. Death as a result of a car wreck is the quintessential accident under the general understanding of that term. It is arbitrary and capricious for an insurer to deny a claim based upon an interpretation of

"accident" that is not stated in the policy and that is contrary to the expectations of the ordinary insured. Therefore, the Court finds in favor of the Plaintiff with respect to the defense that Mr. Buce did not die as a result of an accident.

C. THE INTOXICATION EXCLUSION.

With respect to Defendant's alternative ground for denial of the claim, Plaintiff has shown that a *de novo* review could produce a determination contrary to Defendants' denial of benefits. The 1985 Summary Plan Description did not contain an intoxication exclusion. Allianz denied Plaintiff's claim alternatively in reliance upon the intoxication exclusion found in the 1993 plan booklet. The Court finds as a matter of fact that the Buces never received this plan booklet. Therefore, the 1985 Summary Plan Description is a controlling. "The statute requires that the SPD (summary plan document) be comprehensive and accurate and relate information in a way that the average plan participant can understand." Thompson v. Federal Express Corp., 809 F.Supp. 950, 956 (M.D. Ga, 1992) (citing 29 U.S.C. §1022(a)(1)). When a summary plan document[3] conflicts with the plan, the summary controls. McKnight v. Southern Life & Health Ins. Co., 758 F.2d 1566, 1570 (11th Cir. 1985). The 1985 Summary Plan Description contained a list of policy exclusions that did not include an exclusion for injuries due to intoxication. Plaintiff testified that she relied upon the 1985 Summary Plan Description in deciding not to request an immediate autopsy. This testimony was

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It is undisputed that the summary received by the Buces qualifies as a summary plan document within the meaning of ERISA. See Hicks v. Fleming Cos., 961 F.2d 537 (5th Cir. 1992).

uncontradicted and the Court accepts it as credible. This satisfies the requirement of reliance. Branch 955 F.2d at 1579.

As noted above, the insurance company had a direct conflict of interest when it denied the claim based upon the intoxication exclusion. The Court must evaluate whether Defendants have "justifie[d] their [determination] on the ground of its benefit to the class of all participants and beneficiaries." Cargile, 748 F.Supp. at 879. Defendants have offered no evidence to show that their determination benefits the class. As held in Brown, "[t]he presumption that the fiduciary is acting for the future stability of the fund cannot be entertained." Brown, 898 F.2d at 1568. Defendants may "purge the taint of self-interest" only by showing that "the facts ... bear out [its] assertion that its interpretation of its policy is calculated to maximize the benefits available to plan participants and beneficiaries at a cost the plan sponsor can afford (or will pay)." Id. Defendants have not made such a showing. Denying benefits based upon an unenforceable exclusion that was not contained in the Summary Plan Description is arbitrary and capricious. Thus, in the final analysis, the result is the same whichever standard of review is employed. The denial of benefits was arbitrary and capricious and the Plaintiff is entitled to the death benefit due under the Plan.

CONCLUSION

In summary, Mr. Buce died in an accident and his widow is entitled to the death benefit for which he paid the premiums due for more than 10 years. The Clerk is directed to enter judgment in favor of the Plaintiff in the principal amount of $150,000 with prejudgment interest at the rate of seven (7%) percent per annum. from March 12, 1996 (the date the claim was initially denied) through the date of judgment, plus post-judgment interest and costs against the Defendant Allianz Life

Insurance Company, f/k/a North American Life and Casualty Company. The Plaintiff s application for attorney's fees and expenses shall be submitted in accordance with Local Rule 54.2. The Plaintiff having failed to show a breach of fiduciary duty by Defendants National Service Industries Inc., American Special Risk Management Corporation and National Service Industries Personal Accident Insurance Plan, the Clerk is directed to enter judgment in favor of those Defendants as to this claim.

SO ORDERED, this 16 day of November, 1999.

S/
THOMAS W. THRASH, JR.
United States District Judge

APPENDIX "D"

29 U.S.C. Sec. 1022

Summary plan description:

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 1191b(a)(1) of this title), whether a health insurance issuer (as defined in section 1191b(b)(2) of this title) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee

or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this chapter and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 1191b(a)(1) of this title) and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).